

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If possible, it should be executed by the Deputy Medical Examiner. If not possible, it should be executed by the Medical Director or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FURNER DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

TO FURNER DIRECTOR: Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FURNER DIRECTOR: Page 6 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

FOR STATE  
HEALTH DEPT.

V5. A15ME  
5M 9/66

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
10496 MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
Item 9 Film 6297 10/5/61 iwk													
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6212 - 41st. Place</b>						d. STREET ADDRESS <b>6212 41 st Place</b>							
3. NAME OF DECEASED (Type or print) <b>Robert William Albright</b>						4. DATE OF DEATH Month <b>September</b> Day <b>27</b> Year <b>1961</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>June 30, 1910</b>		9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>15</b> Hours <b>50</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Airplane</b>				11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>			
13. FATHER'S NAME <b>William Ellsworth Albright</b>						14. MOTHER'S MAIDEN NAME <b>Emma Jane Walser</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes 1928-1932</b>						16. SOCIAL SECURITY NO. <b>543-07-4873</b>							
17. INFORMANT <b>Helen Albright Winfree, same as # 2</b>						Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary artery disease</b> DUE TO (a), stating the underlying cause last. (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>James I. Boyd</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
						DATE SIGNED <b>Sept. 27, 1961</b>							
						Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>				22b. DATE THEREOF <b>SEPT 30, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>				22d. LOCATION (City, town, or country) (State) <b>BLADENSBURG, MARYLAND</b>			
23. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, Md.</b>						24a. REC'D BY REGISTRAR <b>OCT 2 61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>					

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10497

10491

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN 1b <b>13 hours</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Prince Georges</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>44 Cottage City</b> d. STREET ADDRESS <b>3707 43rd Avenue</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Eugene Leland Memorial Hospital</b> First <b>Belle</b> Middle <b>Vista</b> Last <b>Allison</b>				<b>4. DATE OF DEATH</b> Month <b>Sept.</b> Day <b>12</b> Year <b>19 61</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>Aug. 24, 1883</b>		<b>9. AGE</b> (In years last birthday) <b>78 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own home</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Glen Rock, Pennsylvania</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>			
<b>13. FATHER'S NAME</b> <b>Thomas R. Herbert</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elvirah Kerchner</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>Daughter - M. Jones, 3707-43rd Ave</b>			
<b>17. INFORMANT</b> <b>Address Cottage City Md.</b>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(Stroke) Cerebral Hemorrhage</b> 331X DUE TO (b) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (c) <b>atherosclerosis</b> (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from 9-11, 1961, to 9-12, 1961, that (I) (we) last saw the deceased alive on 9-12, 1961, and that death occurred at 11 A.M. from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Louis M. Jimal</b> <span style="float: right;">M.D.</span>							
<b>22b. DATE SIGNED</b> <b>9-12-61</b>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Louis M. Jimal</b>							
<b>22d. ADDRESS</b> <b>Cottage City, Md</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>9-14-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Lutheran Cemetery</b>			
<b>23d. LOCATION</b> (City, town or county) <b>Glen Rock, Penna.</b>		<b>23e. REC'D BY REGISTRAR</b>		<b>23f. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Harris</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Isaac H. Hesterstein, New Freedom, Pa.</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)  
15M 9/60

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">10498</span> <span style="font-size: 1.5em;">10492</span> </div> <b>CERTIFICATE OF DEATH</b> </div>																											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Adelphi</u> c. LENGTH OF STAY IN lb. <u>54</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Paint Branch Nursing Home</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Takoma Park, 12</u> d. STREET ADDRESS <u>7404 Flower Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Leah Ellen Altman</u>			<b>4. DATE OF DEATH</b> <u>Sept 1 1961</u>			<b>5. SEX</b> <u>Fe</u>			<b>6. COLOR OR RACE</b> <u>Wh</u>																		
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>Mar. 20, 1872</u>			<b>9. AGE</b> (In years last birthday) <u>89</u> yrs. <table border="1" style="display: inline-table;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>			IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.											
IF UNDER 1 YEAR		IF UNDER 24 HRS.																									
Months	Days	Hours	Min.																								
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Book Keeper - Mary. Book &amp; Bible House</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Colorado</u>						<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b>																					
<b>13. FATHER'S NAME</b> <u>Hiram T. Vandermark</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Jane Jones</u>																					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						<b>16. SOCIAL SECURITY NO.</b> <u>None</u>																					
<b>17. INFORMANT</b> <u>Nursing Home Records.</u>																											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <table border="1" style="width: 100%;"> <tr> <td colspan="4"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Transition</u>  <u>502</u> </td> <td colspan="4"> <b>DUE TO</b>  <b>(b)</b> <u>Chr. Bronchitis</u> </td> </tr> <tr> <td colspan="4"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> </td> <td colspan="4"> <b>DUE TO</b>  <b>(c)</b> </td> </tr> </table>												<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Transition</u> <u>502</u>				<b>DUE TO</b> <b>(b)</b> <u>Chr. Bronchitis</u>				<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>				<b>DUE TO</b> <b>(c)</b>			
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Transition</u> <u>502</u>				<b>DUE TO</b> <b>(b)</b> <u>Chr. Bronchitis</u>																							
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>				<b>DUE TO</b> <b>(c)</b>																							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>																											
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)																			
<b>20f. (City or town)</b>				<b>(County)</b>				<b>(State)</b>																			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>?</u> <b>19</b> to <u>Sept 1</u> , 1961, that (I) <del>two</del> last saw the deceased alive on <u>Aug 29</u> , 1961, and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.																											
<b>22a. SIGNATURE</b> <u>Robert A. Hare</u>						<b>22b. DATE SIGNED</b> <u>9/1/61</u>																					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Robert A. Hare M.D.</u>						<b>22d. ADDRESS</b> <u>7600 Carroll Ave. T. PR. Md.</u>																					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>Sept 5 - 1961</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>X</u>																			
<b>23d. LOCATION</b> (City, town or county) <u>Colorado Springs Colo.</u>				<b>(State)</b>																							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur Hatters</u>						<b>25a. REC'D BY REGISTRAR</b> <u>SEP 5 '61</u>																					
<b>25b. REGISTRAR'S SIGNATURE</b> <u>C. H. H. Hines</u>																											

MEDICAL CERTIFICATION

1

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY in lb <b>D.O.A.</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutions: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Richmond</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Richmond</b> d. STREET ADDRESS <b>6509 Hull Street Road</b>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Walter Edward Armes</b>						<b>4. DATE OF DEATH</b> <b>September 7, 19 61</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>September 17/12 48<sup>st</sup></b>		<b>9. AGE</b> (In years last birthday) <b>48<sup>st</sup></b>		<b>10. IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Heavy Equipment</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Construction</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S.A.</b>	
<b>13. FATHER'S NAME</b> <b>James John Armes</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Lou Frost</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>UNKNOWN</b>		<b>17. INFORMANT</b> <b>2235 Arton St. Pauline Armes, Oxon Run Hills, Md</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO <b>Coronary heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>425.1</b>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <i>James I. Boyd</i> <b>M.D.</b> <b>EXAMINER'S NAME</b> (Type) <b>James I. Boyd</b>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <b>Sept. 7, 1961</b>					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>9-10-1961</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>TUSKIA CHURCH CEMETERY</b>		<b>22d. LOCATION</b> (City, town, or country) <b>LUNENBURG CO. VIRGINIA</b>					
<b>23. FUNERAL DIRECTOR</b> <b>W.W. Chambers Co. Riverdale, Md</b>						<b>24a. REC'D BY REGISTRAR</b> <b>SEP 11 '61</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hines</i>			

MEDICAL CERTIFICATION



aligned with the

195

407 (in)

572

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
1SM 9/59

1  
10500

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10494

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville Md</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3808 Powhatan Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>W</b> Last <b>Ault</b>				4. DATE OF DEATH Month <b>September</b> Day <b>19</b> Year <b>1961</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 27, 1904</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D C</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Ray C Ault</b>				14. MOTHER'S MAIDEN NAME <b>Mary E King</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216 09 3131</b>		17. INFORMANT <b>Nellie Mae Ault</b> Address <b>Hyattsville Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Use to assist in funeral</b>							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (This hospital) attended the deceased from <b>4-1</b> <b>1958</b> to <b>9-19</b> <b>1963</b> that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>9-19</b> <b>1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A Deitz</b>				22b. DATE <b>Sept 19, 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>A Deitz</b>	
22d. ADDRESS <b>Hyattsville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/22/61</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>George Washington</b>		23d. LOCATION (City, town, or county) (State) <b>Hyattsville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraw</b>	

(M)

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10802

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1

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 10501 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10495

**1**  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Hill</u> c. LENGTH OF STAY IN <u>4 1/2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8617 Washington Ave</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Hill</u> d. STREET ADDRESS <u>18617 Washington Ave</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Robert Gover Baden</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>Sept 22 1961</u> Month Day Year			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 27, 1884</u> last birthday	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>chief clerk</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Southern Ry.</u>		<b>11. BIRTH PLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>James Early Baden</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Caroline Early</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, No, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>1 M 50 6215</u>		<b>17. INFORMANT</b> <u>James Early Baden</u> Address <u>Box 284 Rd #1</u> Interval between onset and death <u>aspirated mal</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>44</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e):</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>JAMES I. BOYD</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>9/22/61</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>9-26-61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>ST PAUL'S</u>	
<b>23. FUNERAL DIRECTOR</b> <u>W. W. Chambers Co. 517-11th St S.E.</u>				<b>22d. LOCATION (City, town, or country) (State)</b> <u>BADEN Maryland</u>		<b>24a. REC'D BY REGISTRAR</b> <u>SEP 26 '61</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>							



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film G297 10/20/61

10496

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH  
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hyattsville

c. LENGTH OF STAY IN TB

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Carroll Manor, 4922 LaSalle Road.

3. NAME OF DECEASED  
(Type or print)

Vincent William

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Avondale Hyattsville Washington

d. STREET ADDRESS

1730 Lanier Place  
4922 LaSalle Road

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒

4. DATE OF DEATH

September 24, 1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

September 16/71 90<sup>th</sup>

9. AGE (In years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Tailor

10b. KIND OF BUSINESS OR INDUSTRY

Clothing

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Vincent Bailey

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

4000 Mass. Ave N.W.  
Vincent L. Bailey, Washington D.C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Fracture of the right Hip

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell on the floor while going to the bath room

20c. TIME OF INJURY Month, Day, Year

5:00 PM 8/21/61

20d. INJURY OCCURRED

While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

AT nursing Home Avondale P.G. Md

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

James I. Boyd

M.D.

EXAMINER'S NAME (Type)

JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

Sept. 25, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

9/27/61

22c. NAME OF CEMETERY OR CREMATORY

Mt. Olivet

22d. LOCATION (City, town, or country)

Washington

(State)

D.C.

23. FUNERAL DIRECTOR

F. Gasch's Sons

Hyattsville, Maryland

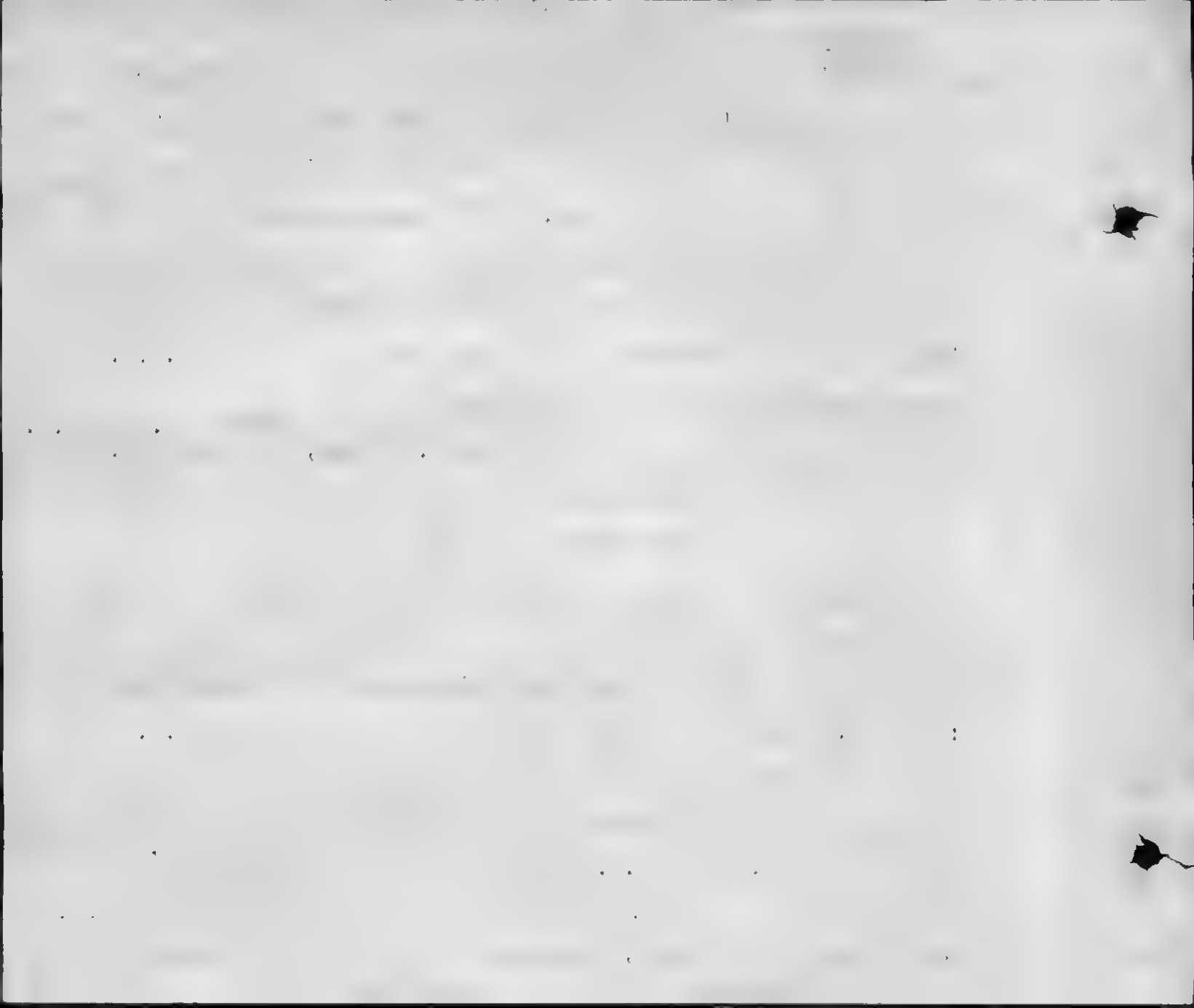
24a. REC'D BY REG STRAR

DATE SEP 29 '61

24b. REGISTRAR'S SIGNATURE

Arthur L. Krueger

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, removal, and in any event within 72 hours after death.



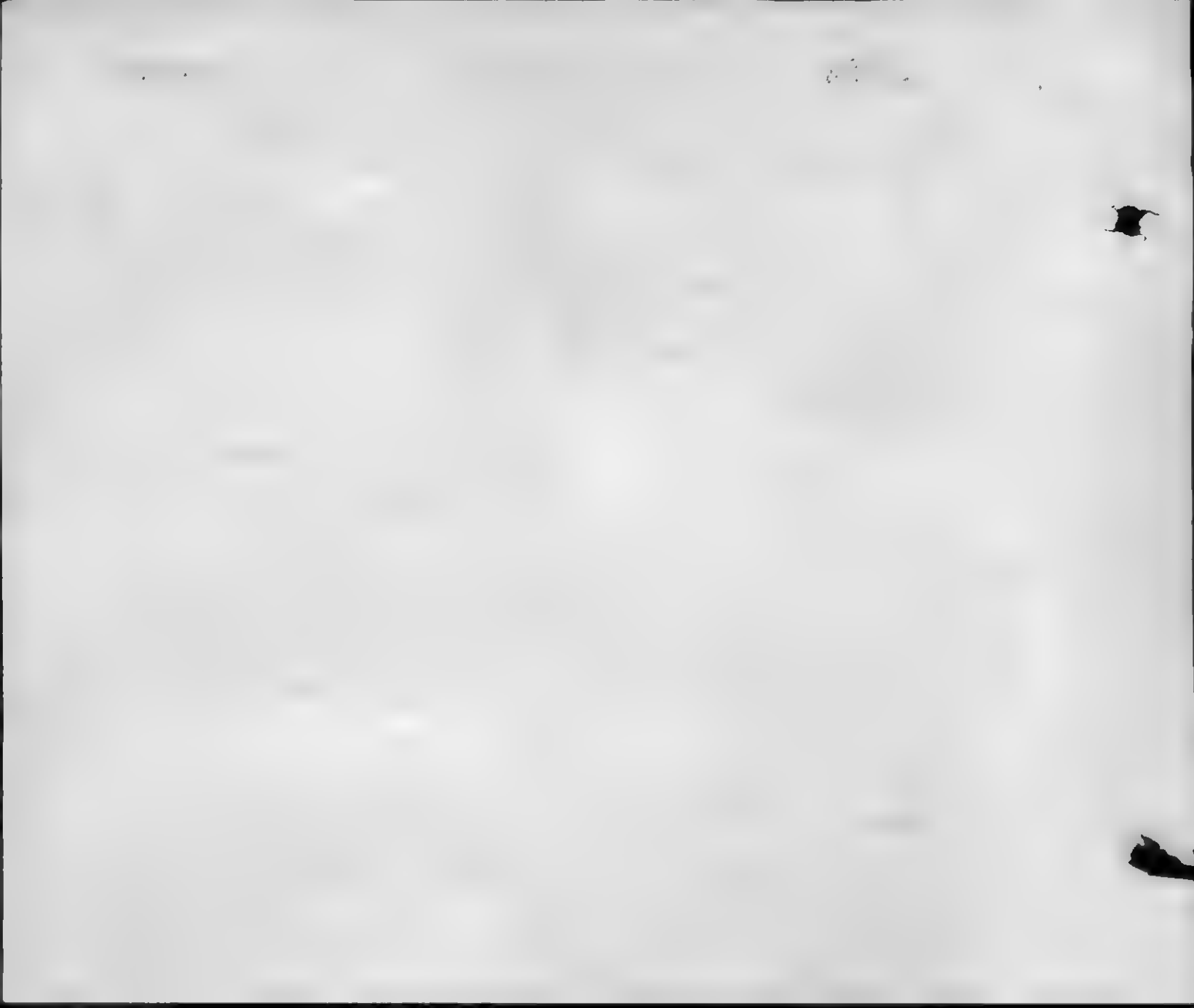
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
10497									
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 3 HRS 53 MIN d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSP, ANDREWS AFB, MD					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY DISTRICT OF COLUMBIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 11 RUDDER GREEN SW				
3. NAME OF DECEASED (Type or print) KAREN ANN 4. DATE OF DEATH Sept 6 1961					5. SEX FEMALE 6. COLOR OR RACE Cauc 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 6 Sept 61 9. AGE (In years last birthday) c 23 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min. 3 53				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE 10b. KIND OF BUSINESS OR INDUSTRY NONE 11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? UNITED STATES					13. FATHER'S NAME JOSEPH GEORGE BARNA 14. MOTHER'S MAIDEN NAME JACQUELINE LOUISE MILLER 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO 16. SOCIAL SECURITY NO NONE 17. INFORMANT FATHER Address SAME AS ITEM #2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 112.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anoxia + Atelelectum (c) Prematurity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 3 53 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					21. I certify that (I) (his hospital) attended the deceased from 6 Sept 1961 to 6 September 1961, and that death occurred at 1030 A.M. from the causes and on the date stated above. 22a. SIGNATURE Hestley D. Stepp Capt USAF (maj) 22b. DATE SIGNED 6 September 61 22c. PHYSICIAN'S NAME Stepp, Hestley D. CAPT USAF MC 22d. ADDRESS USAF Hosp, Andrews AFB, MD 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. ADDRESS 19th. & E St. S.E. Washington, D.C. 22g. LOCATION (City, town or county) (State)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY D.C. Morgue 23d. ADDRESS 23e. REC'D BY REGISTRAR 23f. REGISTRAR'S SIGNATURE SEP 13 '61 Charles L. Kline					24. FUNERAL DIRECTOR'S SIGNATURE 24b. ADDRESS 24c. DATE				

2050235X



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

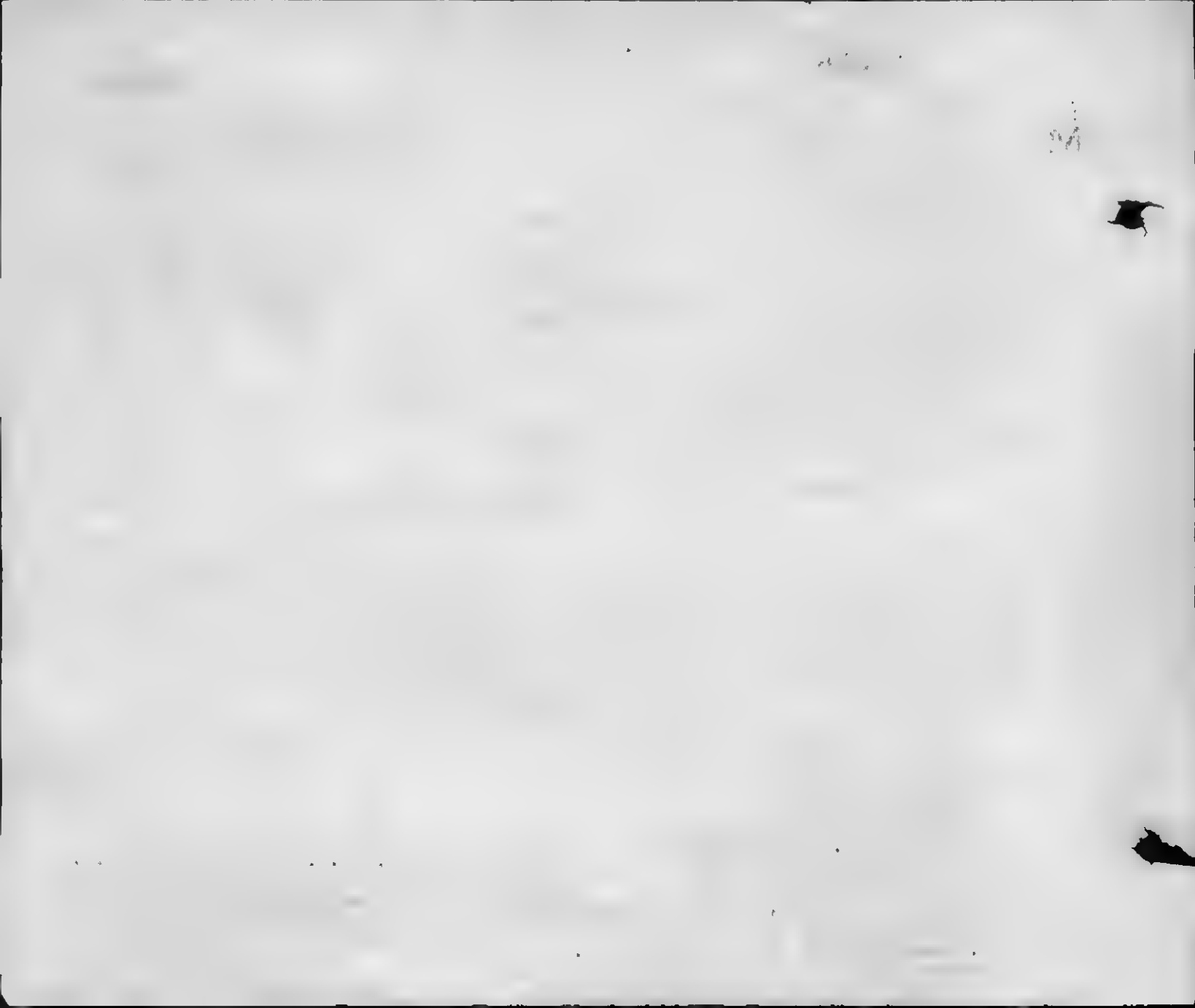
VR A15 (4)  
15M 9/60

10504

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10498

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN <u>20 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>LANDOVER</u> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Minnie E. BARNACK</u>		4. DATE OF DEATH <u>Sept. 15</u> 19 <u>61</u>		5. SEX <u>FEMALE</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 13, 1902</u>	
9. AGE (In years (If UNDER 1 YEAR last birthday) Months Days Hours M.n. <u>58</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Housewife Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Eugene Windsor</u>		14. MOTHER'S MAIDEN NAME <u>Fannie E. Ferguson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Helen Alvey - Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) <u>Sub Arterial Sudden Reaction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>4 days</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2 - 1 - 1961</u> to <u>9 - 15 - 1961</u> , that (I) (we) last saw the deceased alive on <u>9 - 15 - 1961</u> , and that death occurred at <u>7:20 p.m.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Dr. Saul Schwartzbach</u>		22b. PHYSICIAN'S NAME (Type) <u>DR. SWARTZBACH</u>		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <u>1726 Eye St., N.W. Washington 6, D.C.</u>		22e. DATE SIGNED		22f. DATE	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 19, 1961</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Arlington National</u>	
23d. LOCATION (City, town or county) <u>Arlington</u>		23e. (State) <u>Virginia</u>		23f. LOCATION	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		24a. ADDRESS <u>Hyattsville, Md.</u>		24b. REC'D BY REGISTRAR <u>SEP 21 '61</u>	
24c. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>		24d. DATE		24e. REGISTRAR'S SIGNATURE	



TO HO... OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

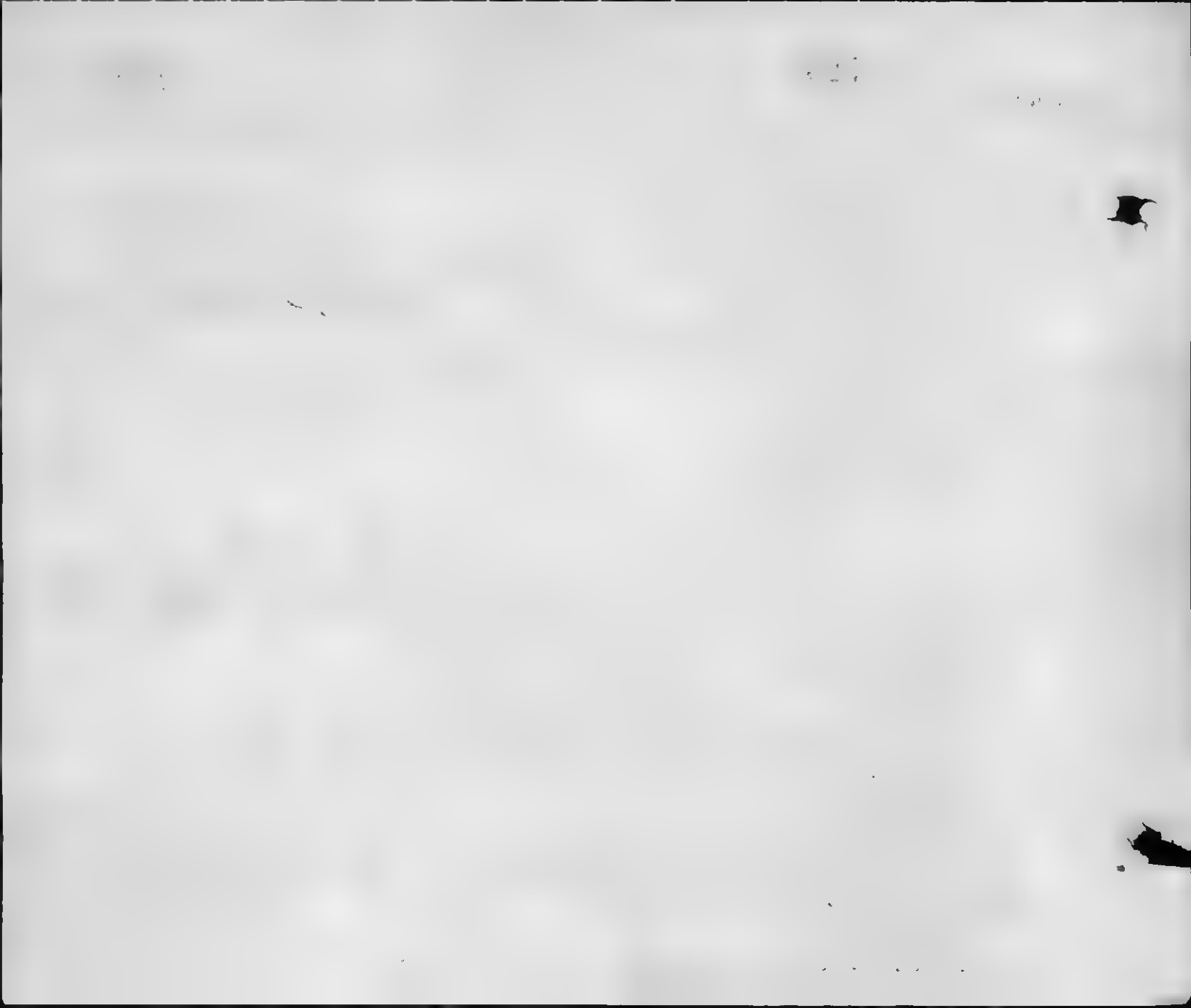
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10505

## CERTIFICATE OF DEATH

10499

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutional residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PG</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u> d. STREET ADDRESS <u>17 A Ridge Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY T. BARNES</u> 4. DATE OF DEATH <u>Sept. 16, 1961</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 7, 1888</u> 9. AGE (In years) <u>73</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> 11. BIRTHPLACE (County & State or foreign country) <u>Canada</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Brannon</u> 14. MOTHER'S MAIDEN NAME <u>Mary Omsby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Thomas J. Barnes</u> Address <u>same as #2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia of Shock</u> DUE TO (b) <u>Septicemic Pseudotuberculosis</u> DUE TO (c) <u>Septicemic Arteritis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>38 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year: <u>Sept 16, 1961</u> Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 15, 1961</u> , to <u>Sept 16, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 16, 1961</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William C. Weintraub</u> M.D.		22b. DATE SIGNED <u>9-16-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>William C. Weintraub</u>		22d. ADDRESS <u>9E Parkway, Greenbelt, Md</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Burial 9/19/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery, Wash. D. C.</u>	
23d. LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u> ADDRESS <u>5801 Cleveland Ave.</u>	
25a. REC'D BY REGISTRAR <u>SEP 19 1961</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

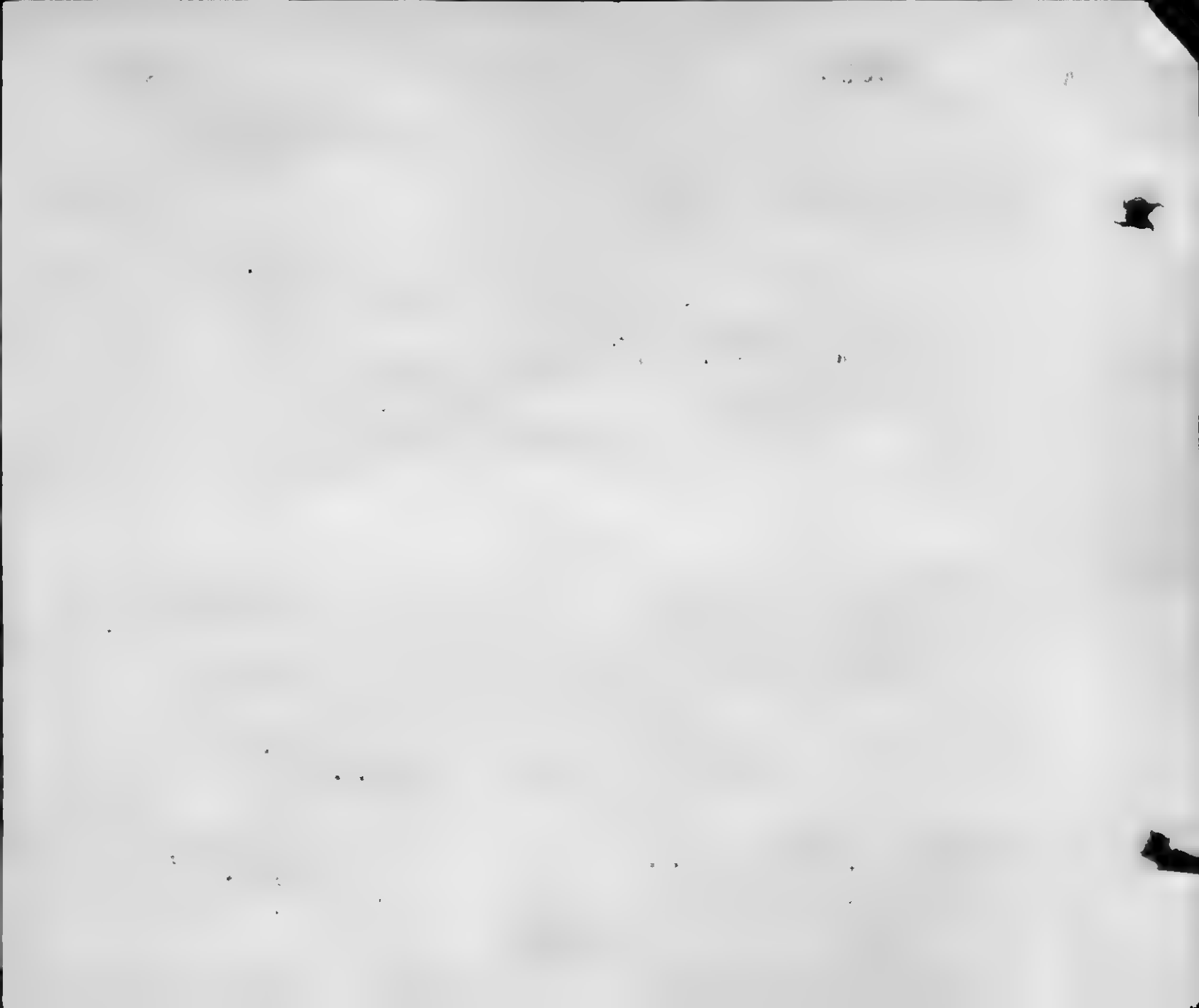
VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10506

10500

1. PLACE OF DEATH a. COUNTY <u>Prince George</u>		2. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>5707 Longfellow Street</u>	
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>BERNARD</u> Middle <u>Belt</u> Last		4. DATE OF DEATH <u>Sept. 30 19 61</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 7, 1893</u>	
9. AGE (in years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D. C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Belt</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mrs. Bernadine M. Parnell</u>		Address <u>same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA</u> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>BRONCHOGENIC CARCINOMA</u> DUE TO (c) <u>UNKNOWN</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>2-3 MONTHS</u> <u>UNKNOWN</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/23</u> to <u>Sept. 30</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9/30</u> , 19 <u>61</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. James Duke, M.D.</u>			
22b. DATE SIGNED <u>10/1/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. James Duke, M.D.</u>			
22d. ADDRESS <u>6607 Riverdale Road, Riverdale, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>Oct 4, 1961</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem</u>			
23d. LOCATION (City, town or county) (State) <u>Bladensburg, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Riverdale, Md</u>			
25a. REC'D BY REGISTRAR <u>OCT 4 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10507

## CERTIFICATE OF DEATH

10501

**1. PLACE OF DEATH**

a. COUNTY

*Prince Geo County*

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

*Riverdale, Md.*

c. LENGTH OF STAY in 1b

*44 days*

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

*Eugene Leland Memorial*

3. NAME OF DECEASED (Type or print)

First

Middle

*Robert*

*Bell*

*Bierly*

5. SEX

*m.*

6. COLOR OR RACE

*w*

7. MARRIED

☒ NEVER MARRIED

8. DATE OF BIRTH

*4-14-83*

9. AGE (In years last birthday)

*78* yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Proof Reader*

10b. KIND OF BUSINESS OR INDUSTRY

*Govt Printing Office*

11. BIRTHPLACE (County & State or foreign country)

*Texas*

12. CITIZEN OF WHAT COUNTRY?

*U.S.*

13. FATHER'S NAME

*Willis R. Bierly*

14. MOTHER'S MAIDEN NAME

*Sarah Bosard*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

*no*

16. SOCIAL SECURITY NO.

*214-34-6886*

17. INFORMANT

*Record Office 4408 Queensbury Rd.*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

*CORONARY OCCLUSION*

INTERVAL BETWEEN ONSET AND DEATH

*15 MIN*

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)

*CARCINOMA ARTERIOSCLEROTIC HEART DISEASE*

*5 yrs*

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

*CARCINOMA OF Right colon - obstructive*

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED While at work Not White at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 19 ....., to 19 ....., that (I) (we) last saw the deceased alive on 19 ....., and that death occurred at ..... M, from the causes and on the date stated above.

22a. SIGNATURE

*Arthur S. Thoms*

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

23b. DATE THEREOF

*9/22/61*

23c. NAME OF CEMETERY OR CREMATORY

*George Washington*

23d. LOCATION (City, town or county)

*Hyattsville,*

(State)

*Md.*

24 FUNERAL DIRECTOR'S SIGNATURE

*Francis Gasch's Sons*

ADDRESS

*Hyattsville, Maryland*

25a. REC'D BY REGISTRAR

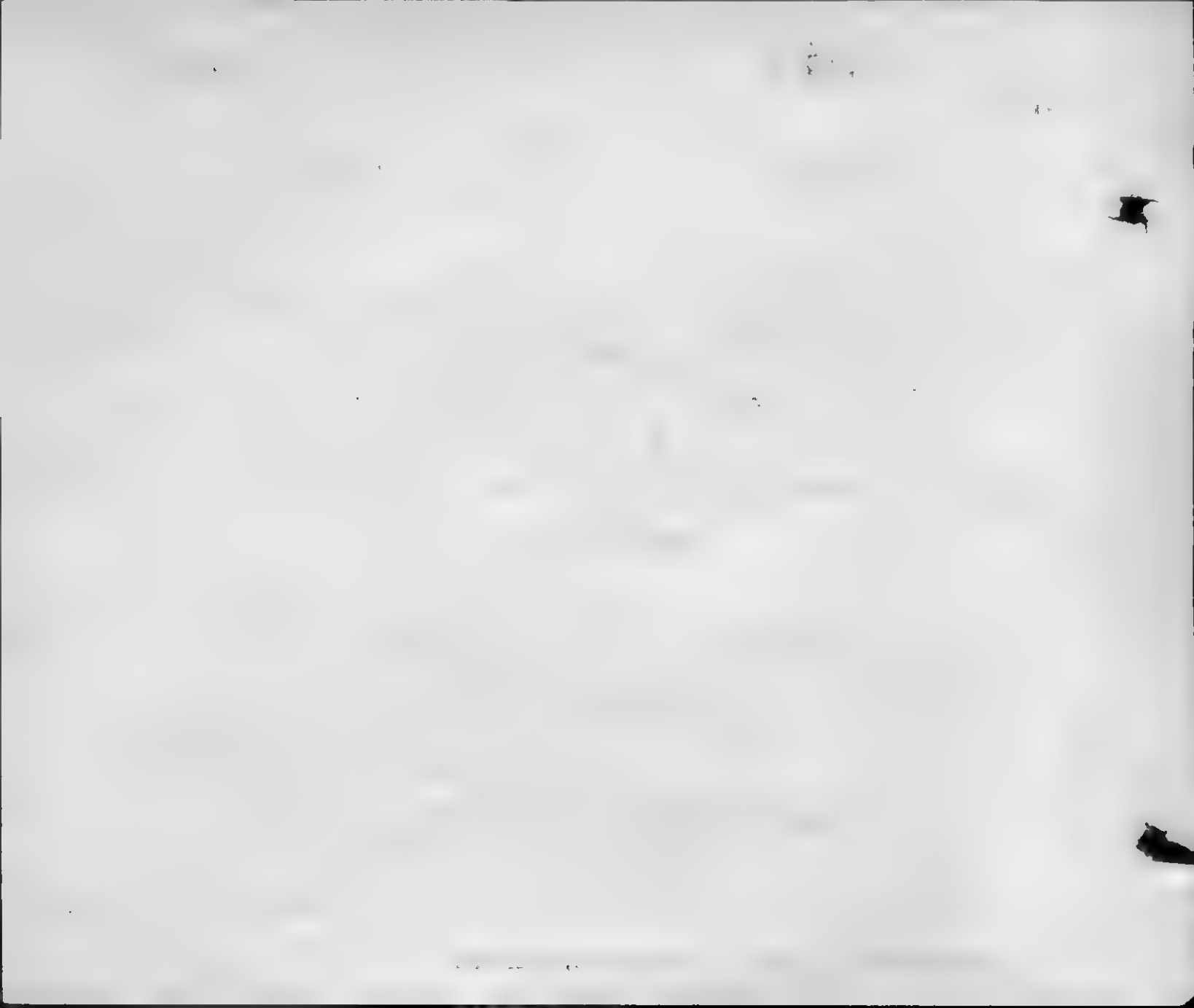
*SEP 21 '61*

25b. REGISTRAR'S SIGNATURE

*Arthur S. Thoms*

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



10508

## CERTIFICATE OF DEATH

Reg. Dist. No.

10508

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>h-h</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel General Hospital</u>		d. STREET ADDRESS <u>Fairview Trailer Court</u>	
3. NAME OF DECEASED (Type or print) <u>Adeline</u> First <u>Price</u> Middle <u>Brewer</u> Last		4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 30, 1887</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jefferson Davis Baldridge</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Gertrude Winsett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>431-05 9639</u>	
17. INFORMANT <u>Mrs Ethel Haley Laurel Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Sigmoid</u> <u>1533</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>B. G. Camp</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct 3, 1961</u>	<u>Linwood Cemetery</u>	<u>Paragould, Arkansas</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Vanalstine, Laurel, Md</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 4 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

TO HOA  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 11 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxan Run	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hosp.				d. STREET ADDRESS 2613 Southern Ave., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph JULES Broches		4. DATE OF DEATH Month Day Year Sept 4 1961		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 30, 1894		9. AGE (In years last birthday) 67 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY General Merchandise		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO 579-18-5921	
17. INFORMANT MRS ROTH GORMLEY		Address 5249 43rd AV. N.W. D.C.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 57°C DUE TO Massive Gastrointestinal Hemorrhage (b) Esophageal & gastric ulceration (c) Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 23 61 to Sept. 4 61, that (I) (we) last saw the deceased alive on Sept. 4 1961, and that death occurred at 10:40 A.M. from the causes and on the date stated above.		22a. SIGNATURE Dr. Samuel S. Sugar, M.D.		22b. DATE SIGNED 9-11-61		22c. ADDRESS 5601 Baltimore Ave., Hyattsville, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9-6-1961		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City, town, or county) (State) BLADENSBURG, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		ADDRESS Riverdale, Md.		25a. REC'D BY REGISTRAR DATE SEP 7 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kneel	

MEDICAL CERTIFICATION



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

10510

10504

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ethel (NMN) Brooke		4. DATE OF DEATH Month Day Year Sept. 5 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 Feb 1897
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James W. Beavers		14. MOTHER'S MAIDEN NAME Sarah C. Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Irene Opitz, 409--57th Ave., Capitol Heights, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Congestive HEART FAILURE (b) DUE TO RENAL FAILURE (ACUTE) (c) DUE TO Arteriosclerotic HEART disease		INTERVAL BETWEEN ONSET AND DEATH 1 mo. 1 wk. many yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 19 61, to Sept. 5, 19 61, that (I) (we) last saw the deceased alive on Sept. 5, 19 61, and that death occurred at 3:35 A.M. from the causes and on the date stated above			
22a. SIGNATURE W.B. Sheer M.D.		22b. DATE SIGNED 9-5-61	
22c. PHYSICIAN'S NAME (Type) WALTER B. SHEER		22d. ADDRESS 7200 MARLBORO PIKE - WASH. 28, D.C.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/8/1961	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland Rd. Pr. Geo. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 51711 <sup>th</sup> St. S.E.		25a. REC'D BY REGISTRAR DATE SEP 6 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION



10511

## CERTIFICATE OF DEATH

Reg. Dist. No.

10505

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR BROWN				4. DATE OF DEATH Month Day Year September 27, 1961			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-27-1888	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William Brown				14. MOTHER'S MAIDEN NAME Viola Guy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Nettie Brown	
				Address		Bowie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Renal Disease 142X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none INTERVAL BETWEEN ONSET AND DEATH Aug. 20 1956							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 20, 1956, to Sept. 27, 1961, that I last saw the deceased alive on Sept. 27, 1961, and that death occurred at 9:25 a.m., from the causes and on the date stated above.							
ACTUAL SIGNATURE G. E. Lancaster				M. D. Bowie		DATE SIGNED 9/27/61	
PHYSICIAN'S NAME (Type) G. E. Lancaster Bowie, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/30/61		22c. NAME OF CEMETERY OR CREMATORY ASCENSION CAT. CH.		22d. LOCATION (City, town, or county) (State) BOWIE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Robert J. McElune				ADDRESS 1825 9TH ST. N.W. WASHINGTON, D.C.		24a. REC'D BY REGISTRAR DATE SEP 29 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10512

10506

FOR STATE  
HEALTH DEPT

1. PLACE OF DEATH  
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

3. NAME OF DECEASED  
(Type or print)

Robert

Lawrence

Brumback Jr

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

June 11, 1961

4. DATE OF DEATH

September 2,

19 61

9. AGE (In years last birthday)

21

10. IS RESIDENCE ON A FARM? YES ☐ NO ☒

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

District of Columbia USA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Robert Lawrence Brumback Sr

14. MOTHER'S MAIDEN NAME

Joyce Ann Kite

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Robert L. Brumback Sr. same as # 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

490X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PNEUMONIA, BILATERAL

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Hour a.m.  
p.m.

Month, Day, Year  
19

20d. INJURY OCCURRED  
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

*James I. Boyd*

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

Sept. 2, 1961

NAME (Type)

JAMES I. BOYD, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

9-5-61

22c. NAME OF CEMETERY OR CREMATORY

Cedar Hill

22d. LOCATION (City, town, or country)

Suitland, Md.

(State)

23. FUNERAL DIRECTOR

Lee Funeral Home - Washington D.C.

ADDRESS

24a. REC'D BY REG STRAR

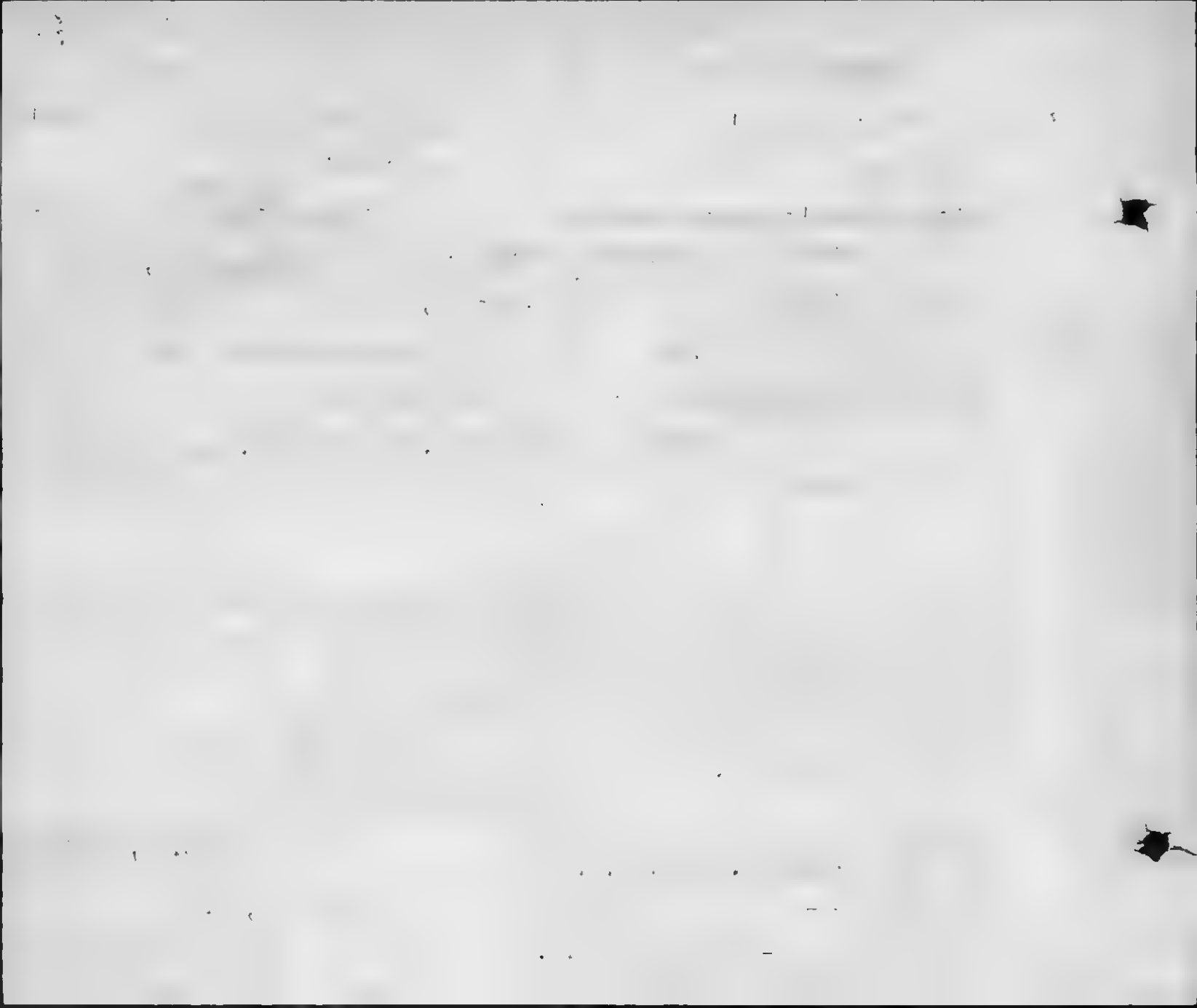
SEP 7 '61

DATE

24b. REGISTRAR'S SIGNATURE

*Arthur L. Kraus*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10513

10507

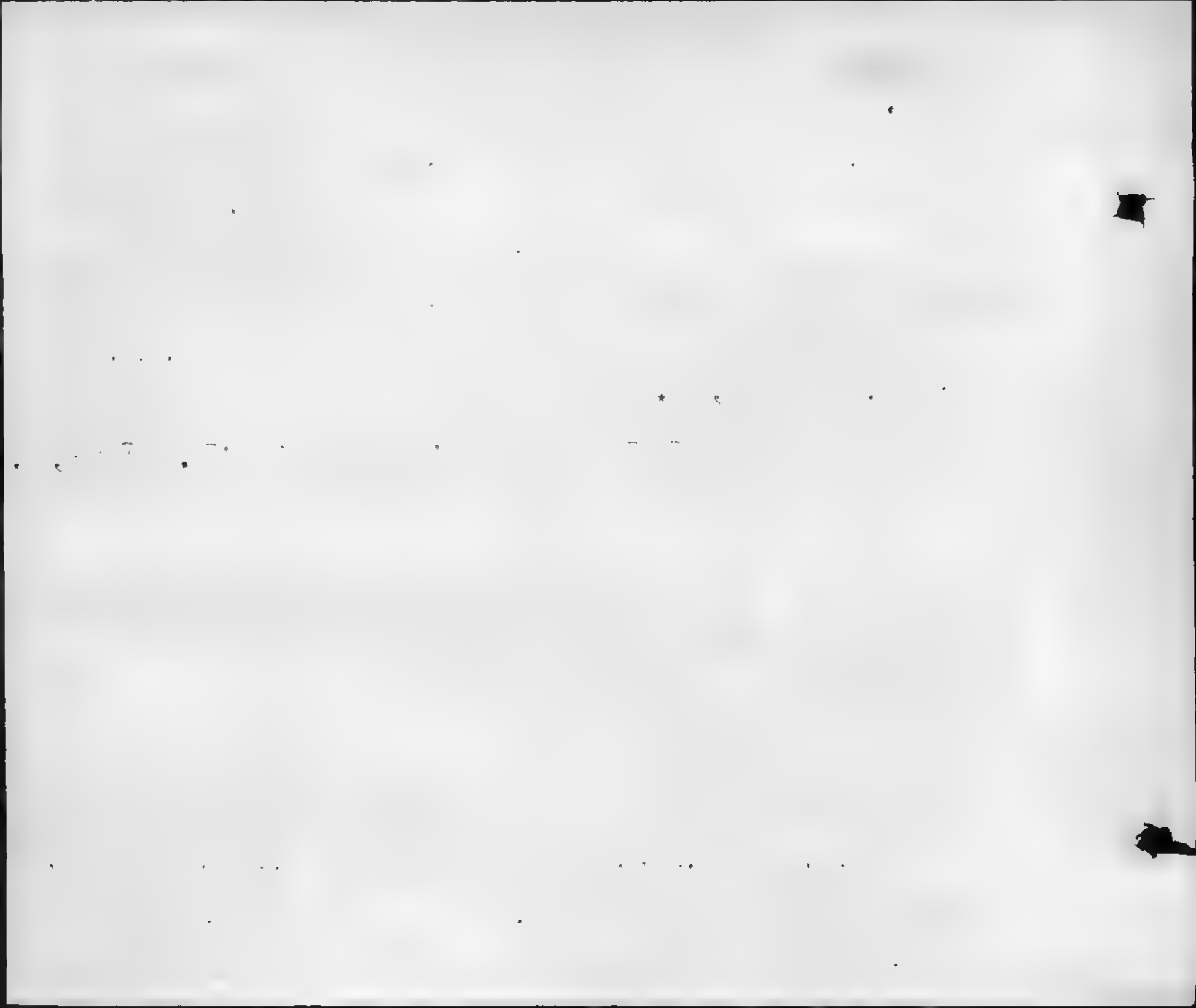
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN TB <b>5 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. STREET ADDRESS <b>3252 Queenstown Dr.</b>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>T</b> Last <b>Burkhardt Jr</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>1</b> Year <b>19 61</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 Oct. 1919</b>
9. AGE (In years lost birthday) <b>41 yrs.</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min. <b>11</b>	11. IF UNDER 24 HRS Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min. <b>11</b>
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Indiana</b>	
11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter T. Burkhardt, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Mayme Ullery</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>308-10-7050</b>	
17. INFORMANT <b>Walter T. Burkhardt, Sr.</b>		Address <b>3252 Queenstown Drive - Mt. Rainier, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> 420.0 DUE TO <b>Arteriosclerosis</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> (c) <b>Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>Sept 1</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Sept 1</b> , 19 <b>61</b> , and that death occurred at <b>3:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. L. Levitsky, M.D.</b>		22b. DATE SIGNED <b>September 1, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. L. Levitsky, M.D.</b>		22d. ADDRESS <b>3408 Rhode Island Ave., Mt. Rainier, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/5/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>National Mem. Park</b>		23d. LOCATION (City, town, or county) (State) <b>Falls Church, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Hines Co</b>		25a. REC'D BY REGISTRAR <b>SEP 5 61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

2

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177

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

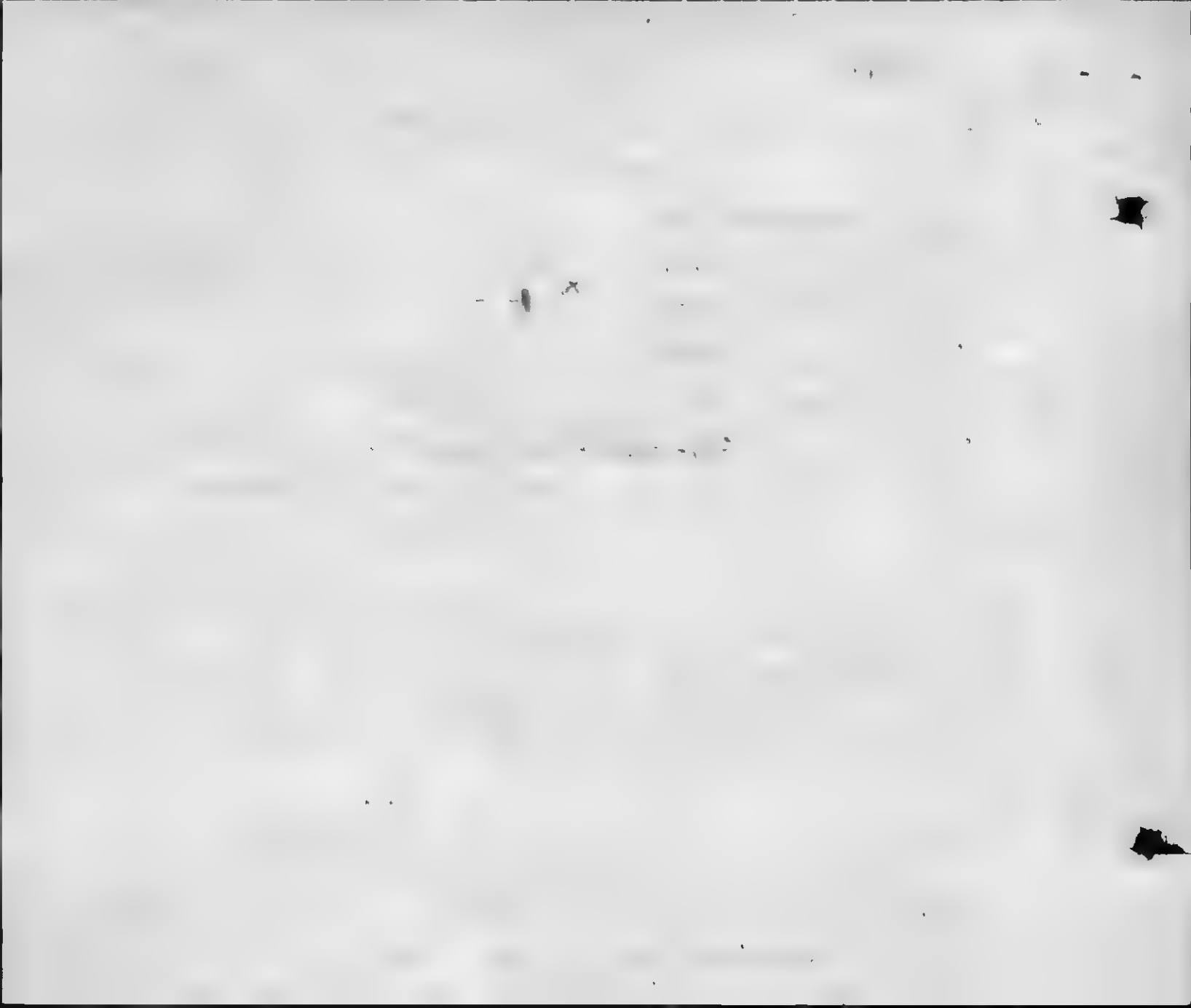
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10514

10508

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>9 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b> d. STREET ADDRESS <b>4450 White Hall Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Paul Edward Burnham</b>		4. DATE OF DEATH <b>September 19 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-18-89</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	
13. FATHER'S NAME <b>Harry Burnham</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>221-14-884</b>	
17. INFORMANT <b>Mrs. Joseph Baden</b>		Address <b>7314 Halleck St. District Hts. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) <b>1 YEAR</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CHRONIC PYELONEPHRITIS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>9/19 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/11</b> , 19 <b>61</b> , to <b>9/19</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9/19</b> , 19 <b>61</b> , and that death occurred at <b>4:15 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Samuel J. N. Sugar</b>		22b. DATE SIGNED <b>9/19/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL J. N. SUGAR</b>		22d. ADDRESS <b>4637 EASTERN AVE WASH DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9-23-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>OLD FIELDS</b>		23d. LOCATION (City, town or county) (State) <b>HUGHESVILLE, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 26 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10515

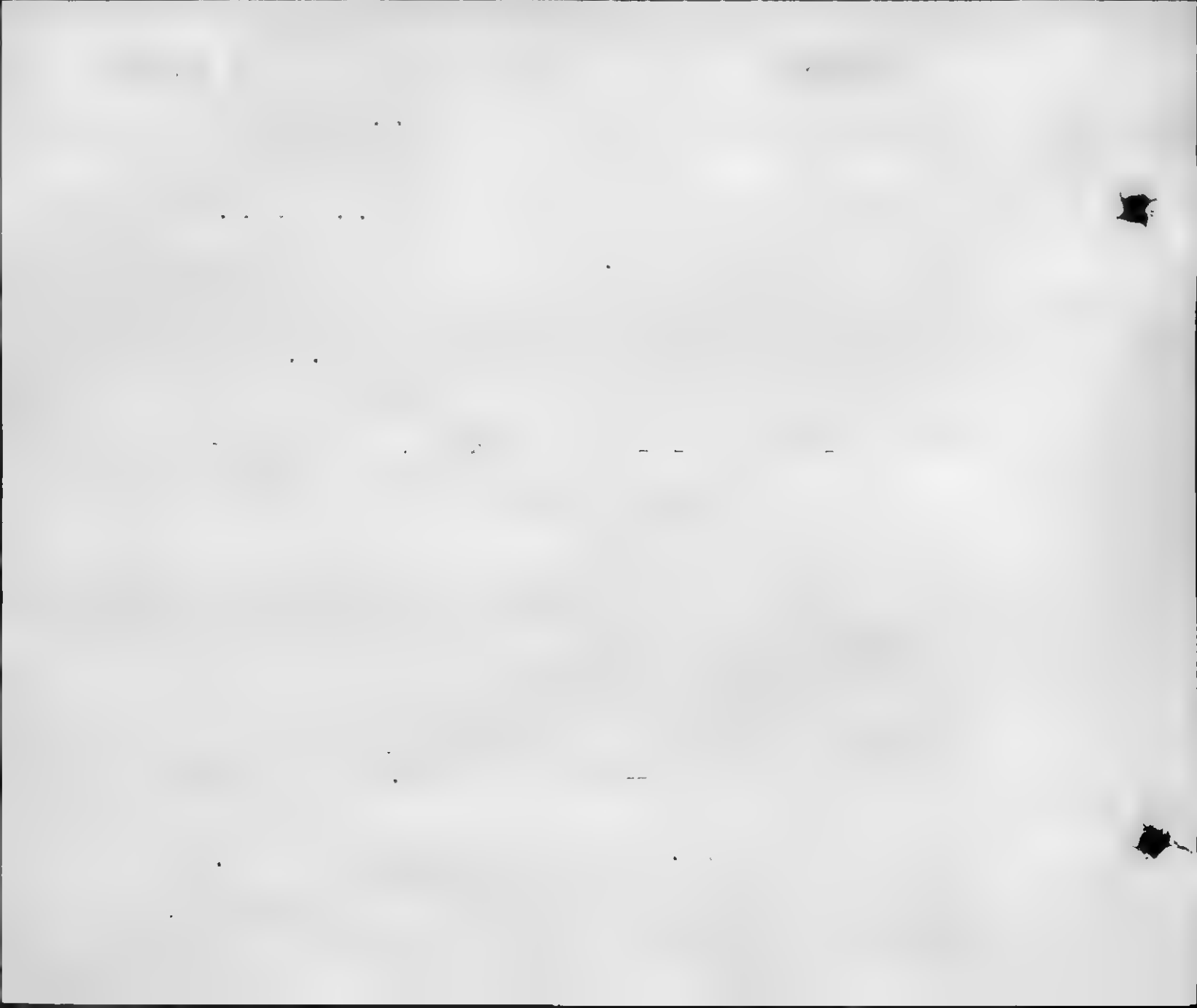
10509

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u> c. LENGTH OF STAY in b. <u>4 months and 23 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Glenn Dale Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>66 N.Y. Ave., N.W., Apt 103</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles</u> Middle <u>L.</u> Last <u>Burton</u> <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Melvern Ice Cream Company</u> <b>13. FATHER'S NAME</b> <u>Basil Burton</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>Unknown</u> <b>16. SOCIAL SECURITY NO.</b> <u>712-03-5013</u> <b>17. INFORMANT</b> <u>Margaret E. Burton Same as # 2 (Wife)</u> Address <u>Washington, D.C.</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Iardella</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>9. AGE</b> (In years last birthday) <u>72</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>—</u> Days <u>—</u> <b>IF UNDER 24 HRS.</b> Hours <u>—</u> Min. <u>—</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, D.C.</u> <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma, left lung, squamous cell type</u> (b) <u>162.1</u> DUE TO <u>type</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>162.1</u> DUE TO <u>type</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4/26/61</u> <u>4:15</u> <b>to</b> <u>9/18/61</u> <u>19</u> <b>that (I) (we) last saw the deceased alive on</b> <u>9/18/61</u> <u>19</u> <b>and that death occurred at</b> <u>P.M.</u> <b>from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <u>Moe Weiss</u> <b>22b. DATE SIGNED</b> <u>9/18/61</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Moe Weiss, M. D.</u> <b>22d. ADDRESS</b> <u>Glenn Dale Hospital</u> <u>Glenn Dale, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>9/22/61</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Glenwood</u> <b>23d. LOCATION (City, town or county)</b> <u>Washington D. C.</u> (State)		<b>25a. REC'D BY REGISTRAR</b> <u>SEP 21 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as file burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

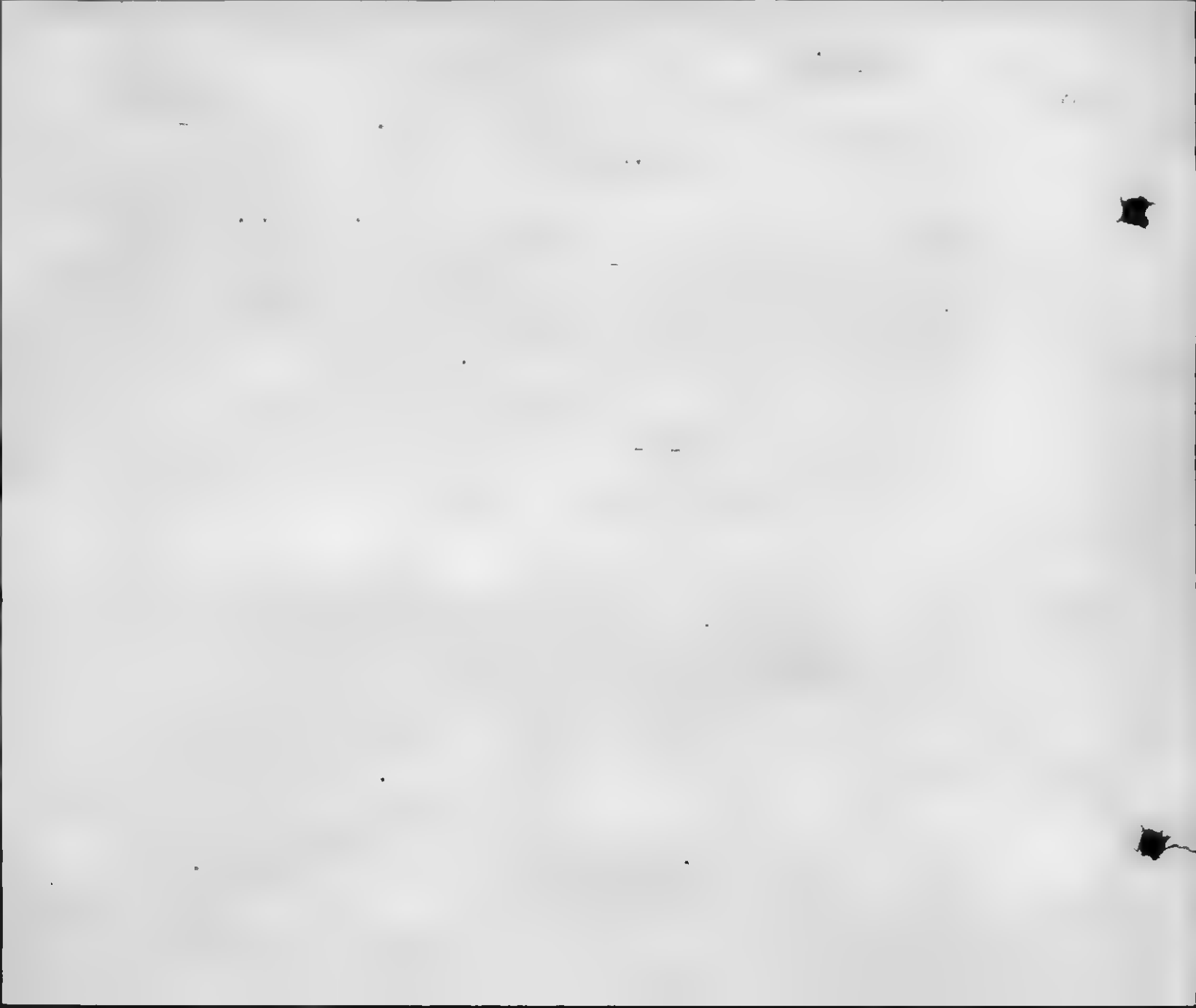
10516

10510

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY in 1b <b>1 yr., and 2 months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residents before admission) a. STATE <b>D. C.</b> b. COUNTY <b>-</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>611 N. St., N.W.</b> e. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Irma</b> First <b>Butler</b> Last		4. DATE OF DEATH Month <b>9</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>but separated</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/4/20</b>
9. AGE (in years last birthday) <b>40</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ga.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Moses Terrell</b>	
14. MOTHER'S MAIDEN NAME <b>Elsie Butler</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Unknown</b>	
16. SOCIAL SECURITY NO. <b>579-16-0292</b>		17. INFORMANT <b>Decedent</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, right lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>10/11/61</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis, minimal; left pneumonectomy, 9/11/61; acute pyelonephritis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7/25/1960</b> to <b>9/25/1961</b> , that (I) (we) last saw the deceased alive on <b>9/25/1961</b> , and that death occurred at <b>P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Joe Weiss</b> 22c. PHYSICIAN'S NAME (Type) <b>Joe Weiss, M. D.</b>		22b. DATE SIGNED <b>9/25/1961</b> 22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9-30-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>North Haven</b>	23d. LOCATION (City, town or county) (State) <b>Washington D.C.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Carl Kammann Sr.</b>		25. REC'D BY REGISTRAR <b>OCT 4 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>			

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10517

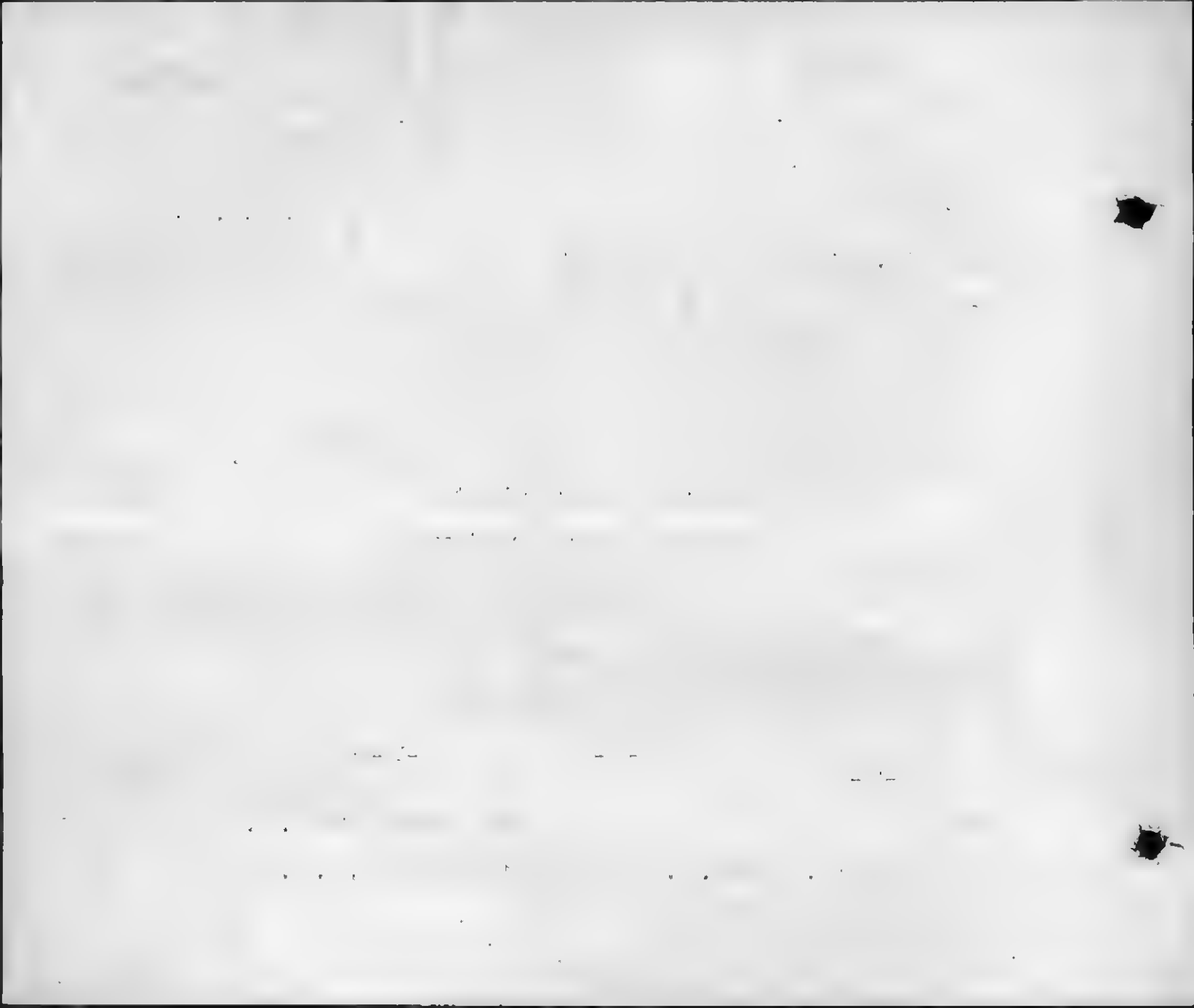
## CERTIFICATE OF DEATH

10517

1. PLACE OF DEATH a. COUNTY <b>Prince Geo.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <b>D.C.</b> b COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>District Hgts.</b>		c. LENGTH OF STAY IN 1b <b>Washington</b> <b>47X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7823 Gateway Blvd.</b>		d. STREET ADDRESS <b>2219 Kearney St. N.E.</b>	
3. NAME OF DECEASED (Type or print) <b>Mrs. Elizabeth Butterworth</b>		4. DATE OF DEATH Month <b>9</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 April 1882</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Joseph Joynson</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Robert Butterworth</b>		Address <b>Same 1 d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>many years</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8-30-61</b> , 19____, to <b>9-18-61</b> , 19____, that I last saw the deceased alive on <b>9-17-61</b> , 19____, and that death occurred at <b>7:30</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7200 Marlboro Pike S. E.</b> DATE SIGNED <b>9-18-61</b> ACTUAL SIGNATURE <b>W. B. Sheer</b> PHYSICIAN'S NAME (Type) <b>Walter B. Sheer M. D.</b> <b>Washington 28, D. C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>20 Sept. '61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home 300-4th St. N.E.D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 20 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HIDE PAGE 4 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
10518					10512				
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>19 HRS 14 MIN</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US AIR FORCE HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRYANS ROAD</b> d. STREET ADDRESS <b>LOT 54, BRYANS ROAD TRAILER/</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>BARBARA</b> <b>JEAN</b> <b>CHOQUETTE</b>					4. DATE OF DEATH <b>SEPTEMBER 28 19 61</b>				
5. SEX <b>FEMALE</b>					6. COLOR OR RACE <b>CAUCASIAN</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>27 SEPTEMBER 1961</b>				
9. AGE (In years last birthday) <b>19</b>					10. IF UNDER 1 YEAR <b>28</b> <b>14</b>				
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>					12. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>				
13. FATHER'S NAME <b>PHILIP H CHOQUETTE</b>					14. MOTHER'S MAIDEN NAME <b>JOYCE I HARRISON</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>					16. SOCIAL SECURITY NO. <b>NONE</b>				
17. INFORMANT <b>NONE</b>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>ANOXIA</b> DUE TO <b>ATELECTASIS</b> DUE TO <b>PREMATURITY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>19 HRS 14 MIN</b> <b>19 HRS 14 MIN</b>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>27 SEPT 19 61</b> to <b>28 SEPT 61</b> 19 <b>61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>28 SEPT 19 61</b> , and that death occurred at <b>6:45 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Richard P. Malsan</b> M.D.					22b. DATE SIGNED <b>28 SEPTEMBER 1961</b>				
22c. PHYSICIAN'S NAME (Type) <b>RICHARD P. MALSAN, Capt USAF MC</b>					22d. ADDRESS <b>USAF HOSP, ANDREWS AFB, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>					23b. DATE THEREOF				
23c. NAME OF CEMETERY OR CREMATORY <b>A.C. Morgan</b>					23d. LOCATION (City, town or county) (State)				
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR <b>OCT 2 '61</b>				
					25b. REGISTRAR'S SIGNATURE <b>John L. Kraus</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1  
(M)

10519

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10513

1. PLACE OF DEATH  
a. COUNTY Prince George's MARYLAND  
b. CITY OR TOWN (If outside corporate limits, give RURAL and give nearest town) Rural Adelphi 2mo. 4da  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Point Branch Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution; Res. since before admission)  
a. STATE MARYLAND PR. Geo.  
b. CITY OR TOWN (If outside corporate limits, give RURAL and give nearest town) Seat Pleasant  
c. STREET ADDRESS 17272 Central Ave.  
d. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Alice Virginia Collins  
First Middle Last  
4. DATE OF DEATH Sept. 21 1961  
Month Day Year

5. SEX F. 6. COLOR OR RACE W. 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐  
8. DATE OF BIRTH Jan. 29, 1868 93 yrs.  
9. AGE (In years; last b. m. d.) 93 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours M. n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY None  
11. BIRTHPLACE (County & State, or foreign country) District of Columbia U.S.A.  
12. CITIZEN OF WHAT COUNTRY? U.S.A.  
13. FATHER'S NAME James E. Harry 14. MOTHER'S MAIDEN NAME Sarah Queen  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Address Paint Branch Nursing Home Records.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) RESPIRATORY ARREST  
331X DUE TO  
Conditions, if any, which gave rise to immediate cause (b) CEREBRAL VASCULAR ACCIDENT  
(Yes, stating the underlying cause last. (c) 48 HRS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  
GENERAL DEBILITY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

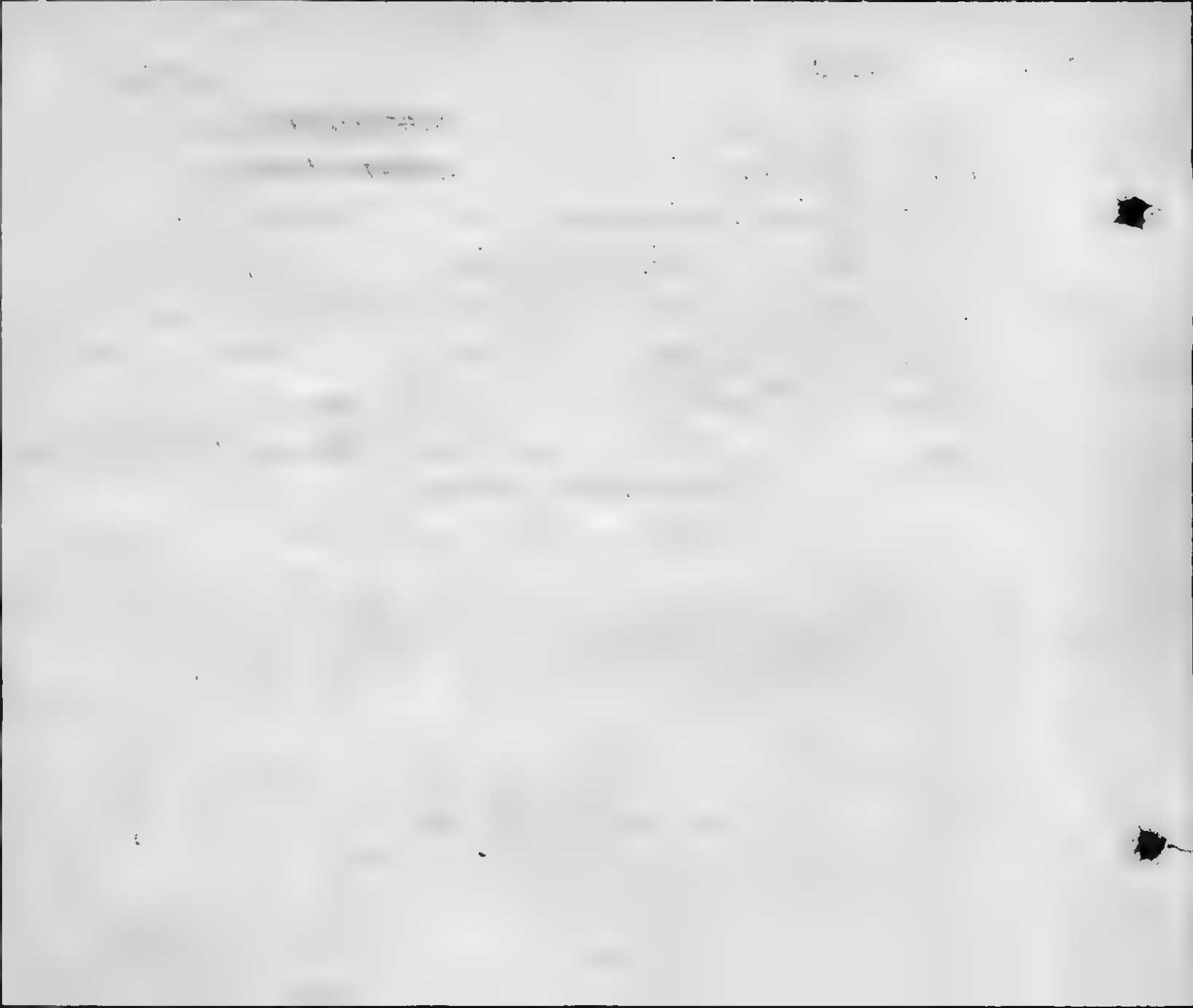
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (the hospital) attended the deceased from 9-19 1961, to 9-21 1961 that (I) (the hospital) last saw the deceased alive on 9-19 1961, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE Morrill C. Quinnam Jr. M.D. 22b. DATE SIGNED 9-21-61  
22c. PHYSICIAN'S NAME (Type) MORRILL C. QUINNAM JR. 22d. ADDRESS 704-DEVINSHIRE RD. TAKOMA PARK MD

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Sept. 23-61 23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cem. 23d. LOCATION (City, town or county) Seat Pleasant MD

24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros 25a. REC'D BY REGISTRAR SEP 25 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Evans



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

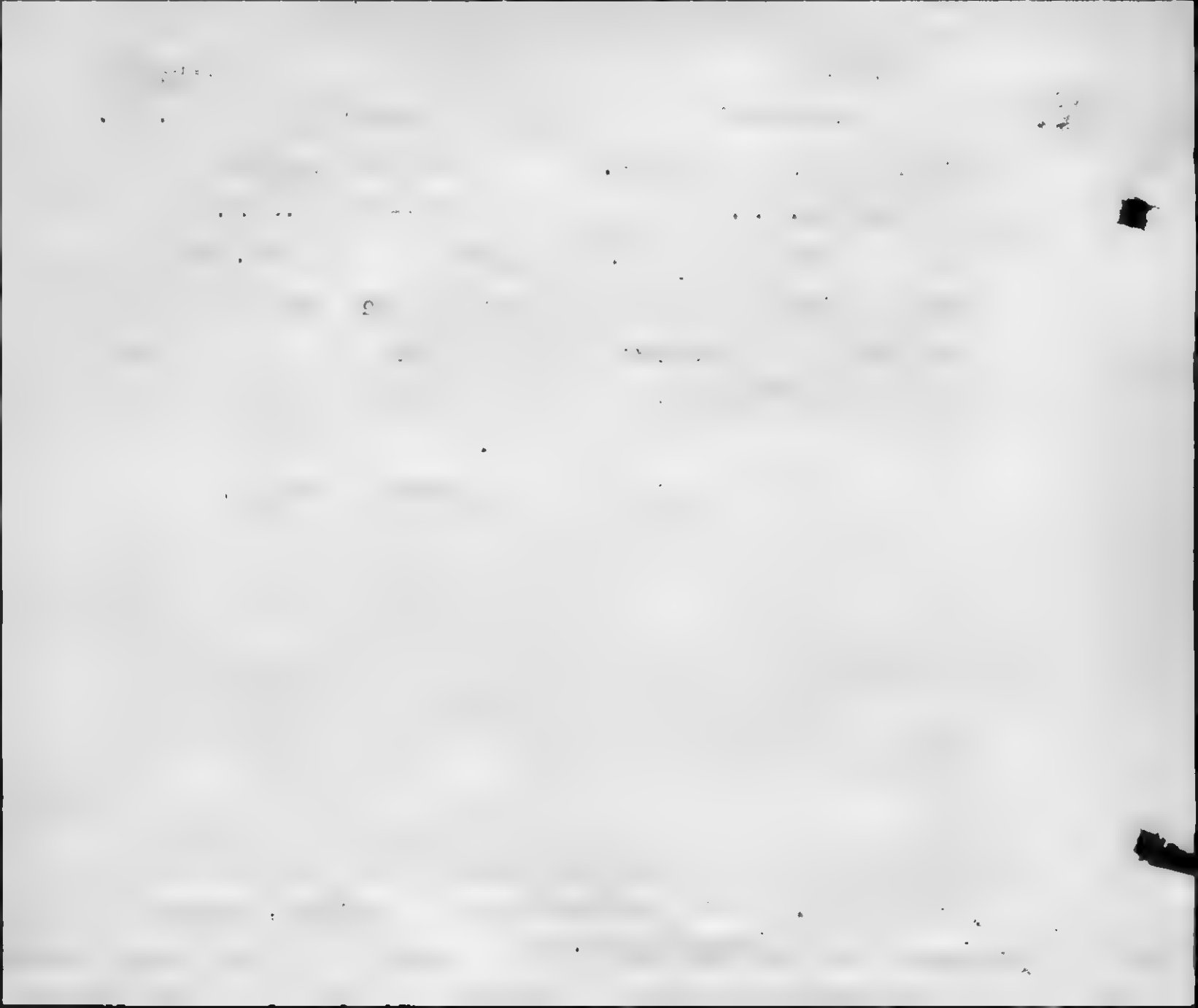
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10520

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10514

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillcrest Hgts		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillcrest Heights	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5807--25th Ave. S.E.		d. STREET ADDRESS 5807--25th Ave., S.E.	
3. NAME OF DECEASED (Type or print) JULIA C.		4. DATE OF DEATH Sept. 25th 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 26, 1892	
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Kendell		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Henry G. Cooke		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 143x Hypertensive arteriosclerotic heart disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to Sept 25, 1961, that (I) (we) last saw the deceased alive on Sept 25, 1961, and that death occurred at J.P. M. from the causes and on the date stated above.			
22a. SIGNATURE Frank J. Talbot		22b. DATE SIGNED 9/25/61	
22c. PHYSICIAN'S NAME (Type) Frank J. Talbot		22d. ADDRESS 4307 Branch Ave 21 DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 28 1961	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 1661--Good Hope Rd., SE Washington 20 DC		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE SEP 28 '61	



# MARYLAND STATE DEPARTMENT OF HEALTH

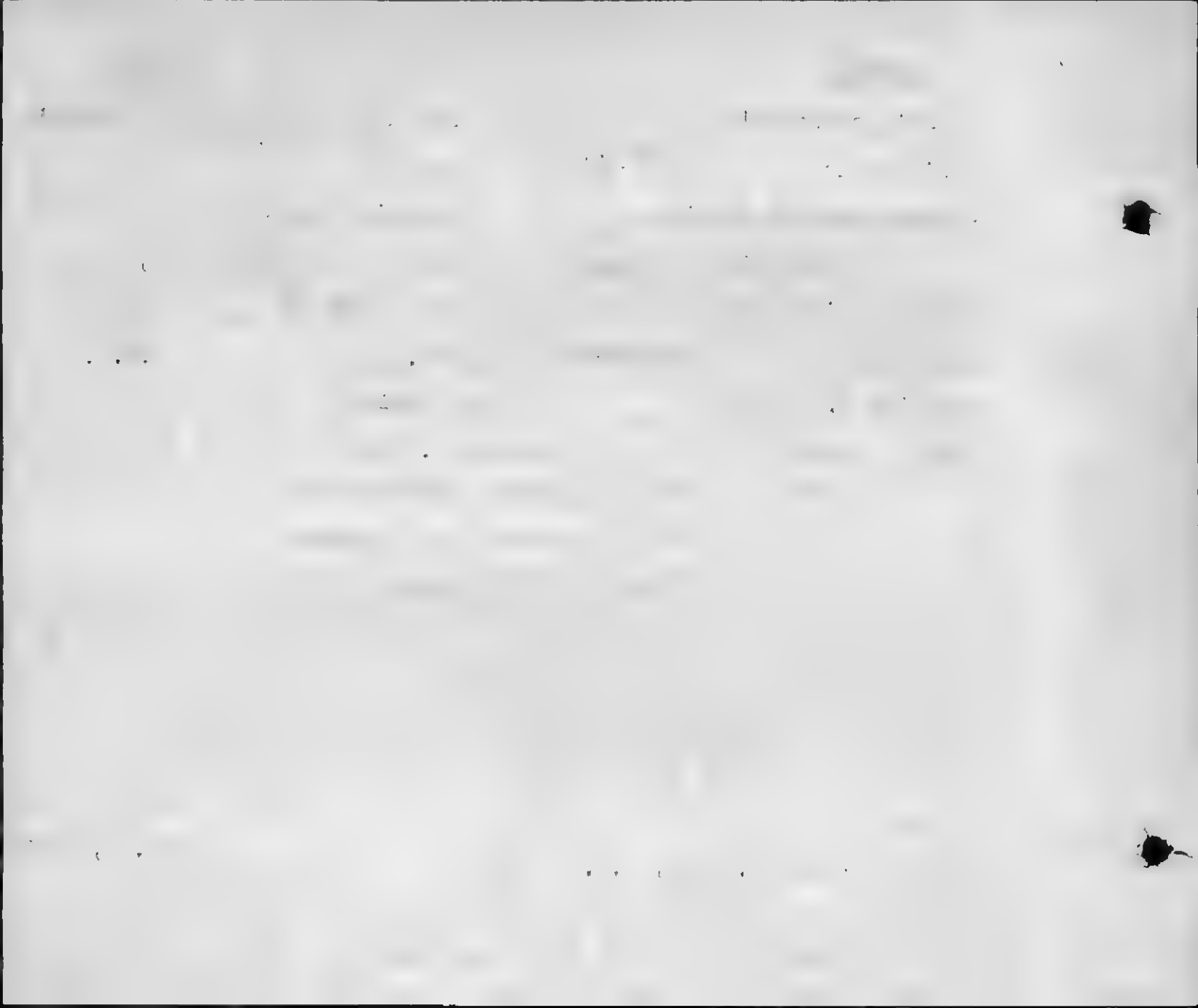
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10515

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

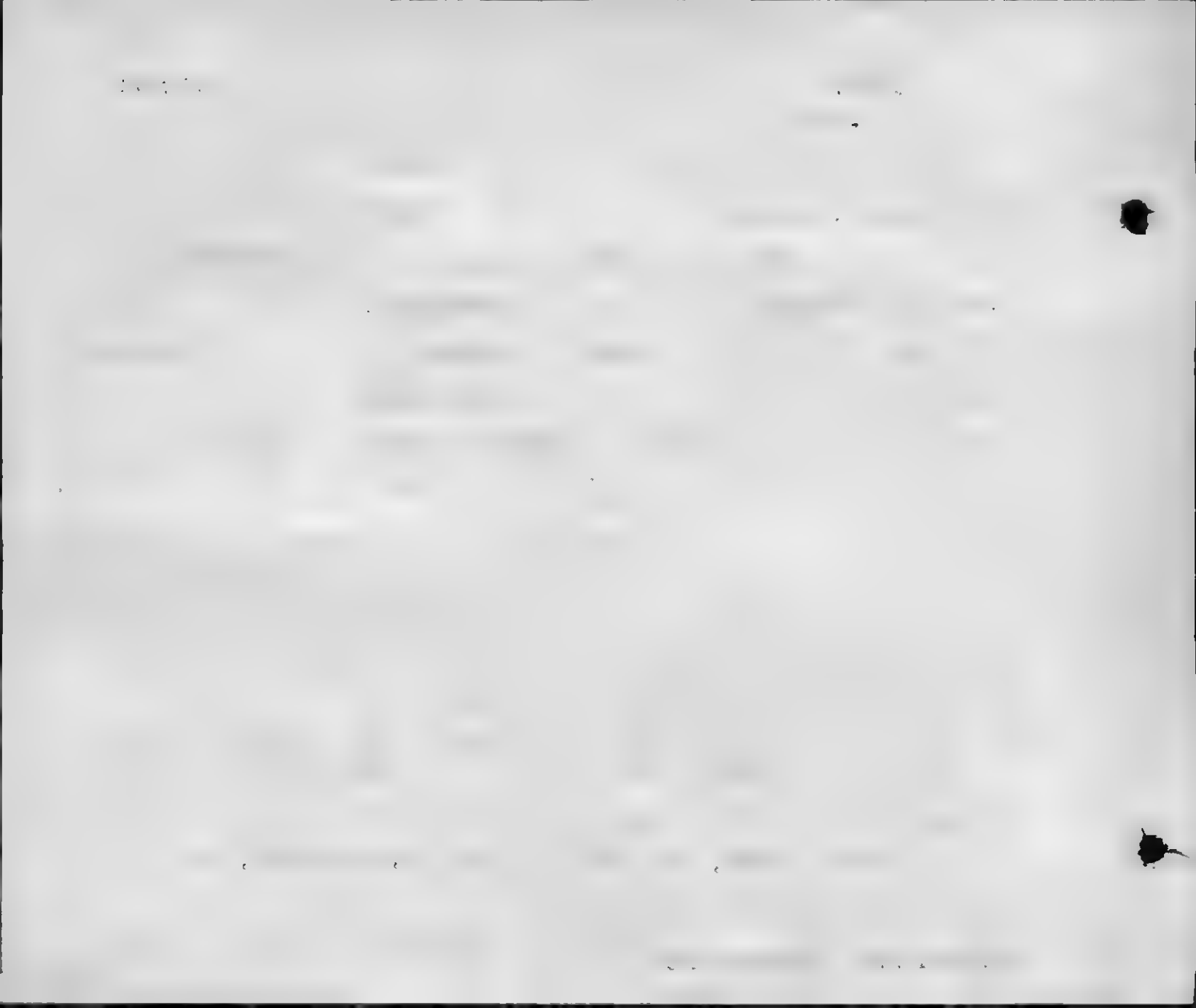
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY in 1b <b>Dead on arrival</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Thomas Cooper</b>	4. DATE OF DEATH <b>September 1, 1961</b>	5. SEX <b>Male</b>	
6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 13, 1903</b> 58 yrs.	
9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman - Merchandise</b>	11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	13. FATHER'S NAME <b>William A. Cooper</b>	14. MOTHER'S MAIDEN NAME <b>Dora Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Marion L. Cooper Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Diabetes several years</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		DATE SIGNED <b>Sept. 1, 1961</b>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5 SEPT. 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>	22d. LOCATION (City, town, or country) (State) <b>SUITLAND MD.</b>
23. FUNERAL DIRECTOR <b>Linaldi Funeral Home, Inc 816 N. E. St.</b>	24a. REC'D BY REGISTRAR <b>SEP 5 '61</b> 24b. REGISTRAR'S SIGNATURE <b>C. Thomas S. Thayer</b>		



# 1 M 1 10522 10516

## 10522 10516

1. PLACE OF DEATH												2. USUAL RESIDENCE (Where deceased lived, if institution, include date of admission)																							
a. COUNTY						b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						a. STATE						b. COUNTY																	
PRINCE GEORGES						MARYLAND						MARYLAND						PRINCE GEORGES																	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						c. LENGTH OF STAY (in days)						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						d. STREET ADDRESS																	
ANDREWS AIR FORCE BASE						2 DAYS						SUITLAND						4799 WHEELER HILLS ROAD																	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
USAF HOSPITAL, ANDREWS AFB																																			
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH			Month			Day			Year														
JOHN			SAMUEL			COX III			SEPTEMBER			22			19			61																	
5. SEX			6. COLOR OR RACE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			8. DATE OF BIRTH			9. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.																	
MALE			CAUCASIAN			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			20 SEPTEMBER 61			yrs.			Months			Days			Hours														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (County & State, or foreign country)						12. CITIZEN OF WHAT COUNTRY?																	
NONE						NONE						MARYLAND						UNITED STATES																	
13. FATHER'S NAME												14. MOTHER'S MAIDEN NAME																							
JOHN S COX												LINDA E MOORE																							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT						Address																	
NO						NONE						HOSPITAL RECORD						SAME AS ITEM #1																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH																							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congenital atelectasis</i>												24 hrs																							
762.5 DUE TO <i>Prematurity</i>												2 days																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)																																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																													
20c. TIME OF INJURY Month, Day, Year						20d. INJURY OCCURRED						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)																	
Hour a.m. p.m.						While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>																													
21. I certify that (I) (this hospital) attended the deceased from 20 SEPT 1961 to 22 SEPT 1961, that (I) (we) last saw the deceased alive on 22 SEPT 1961, and that death occurred at 240A, from the causes and on the date stated above.																																			
22a. SIGNATURE <i>Arnold A. Abram</i>												22b. DATE SIGNED 22 SEPT 61																							
22c. PHYSICIAN'S NAME (Type) ARNOLD A ABRAMQ CAPT USAF MC												22d. ADDRESS USAF HOSP, ANDREWS AFB, MD																							
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify)												23b. DATE THEREOF																							
Burial												9/24/61																							
23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION (City, town or county) (State)																							
Arlington Natl												Arlington Va																							
24. FUNERAL DIRECTOR'S SIGNATURE												25a. REC'D BY REGISTRAR												25b. REGISTRAR'S SIGNATURE											
<i>Rinaldi Funeral Home</i>												816 H ST SE												DATE OCT 2 '61											



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
10523		10517	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
a. COUNTY	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	a. STATE	b. COUNTY
Prince George's	MARYLAND	Maryland	Prince George's
c. LENGTH OF STAY IN 1b	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	d. STREET ADDRESS
Cheverly	Prince George's General Hospital	Landover Hills	3605 64th Avenue
3. NAME OF DECEASED (Type or print)	First Middle Last	4. DATE OF DEATH	Month Day Year
Melinda Sue Cox		September 9 1961	
5. SEX	6. COLOR OR RACE	7. MARRIED	8. DATE OF BIRTH
Female	White	<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> MARRIED	July 22, 1961
9. AGE (In years last birthday)	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. PLACE (County, State, or foreign country)
19	None	None	Cheverly, Maryland
12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	U.S.A.
U.S.A.	Austin Eugene Cox	Mell Laura Louise Conrad	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
Pulmonary Congestion and Edema			
DUE TO			
Subaortic Stenosis			
DUE TO			
Congenital Heart Disease (Hypoplasia of ventricle)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
INTERVAL BETWEEN ONSET AND DEATH			
Since birth			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
no injury			
20c. TIME OF INJURY Month, Day, Year			
20d. INJURY OCCURRED			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)			
(County)			
(State)			
21. I certify that (I) (this hospital) attended the deceased from birth, 1961, to Sept 9, 1961, that (I) (we) last saw the deceased alive on Aug 26, 1961, and that death occurred at 11:45, from the causes and on the date stated above.			
22a. SIGNATURE			
22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)			
22d. ADDRESS			
22e. REC'D BY REGISTRAR			
25b. REGISTRAR'S SIGNATURE			
23a. BURIAL, CREMATION, REMOVAL (Specify)			
23b. DATE THEREOF			
23c. NAME OF CEMETERY OR CREMATORY			
23d. LOCATION (City, town or county)			
(State)			
24. FUNERAL DIRECTOR'S SIGNATURE			
25a. REC'D BY REGISTRAR			
25b. REGISTRAR'S SIGNATURE			
25c. DATE			
25d. ADDRESS			
25e. CITY, TOWN OR COUNTY			
(State)			
(Zip)			
Francis Gasch's Sons			
Hyattsville, Maryland			
SEP 13 '61			
Arthur S. Kraus			

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*[Faint handwritten notes at the bottom of the page]*

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Feb. 25. 1901.

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

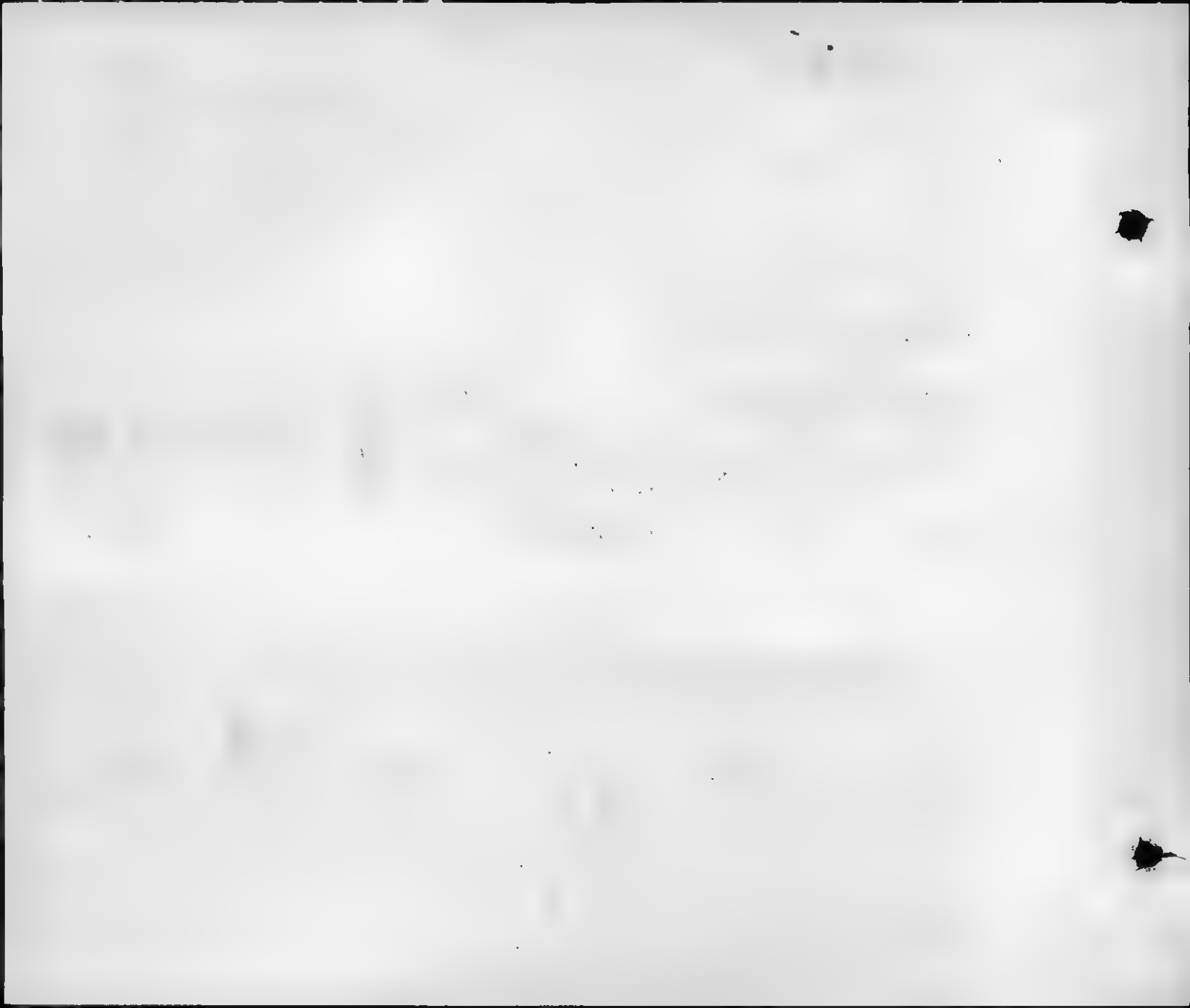
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10524

10518

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-TAKOMA PARK</u>				c. LENGTH OF STAY IN TB <u>5 mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>416 CIRCLE AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>(NMI)</u> Last <u>CRANMER</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 24 1884</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ENGLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>HENRY CRANMER</u>				14. MOTHER'S MAIDEN NAME <u>EMMA HUSK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>1100 New King, 418 Circle Ave, Takoma Park Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CANCER Prostate with metastases.</u> 1777 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <u>  </u>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 1960</u> to <u>Sept 4 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 4 1961</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Ernest A. Sarao</u>				22b. DATE <u>Sept 4, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>ERNEST A. SARAO, M.D.</u>	
22d. ADDRESS <u>TAKOMA PARK, MD.</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> MED. STAFF <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <u>  </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT 7, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WILVET CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ST. MICHAELS MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. Hambleton Harrison, A. Michael</u>				25a. REC'D. BY REGISTRAR <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

md



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

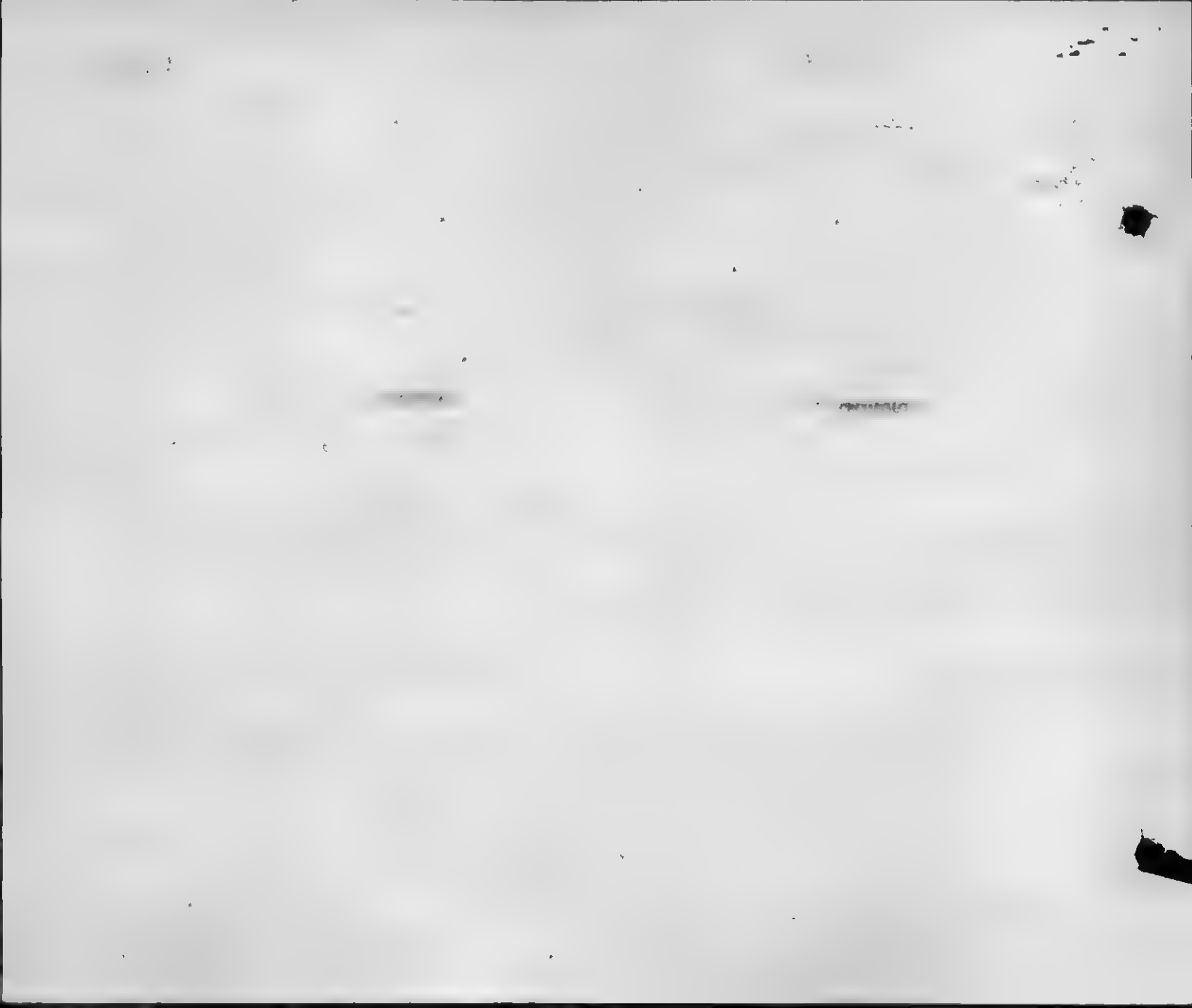
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10525

10519

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4 Southern Md. Hospital Center</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b> d. STREET ADDRESS <b>Rt. 1 Box 187</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Wilbert M.</b> First Middle Last <b>5. SEX</b> <b>M.</b> <b>6. COLOR OR RACE</b> <b>W</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>April 3 1904</b> <b>9. AGE</b> (In years last birthday) <b>57</b> yrs. <b>10. IF UNDER 1 YEAR</b> Months Days <b>11. IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>construction</b> <b>10c. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Ill.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>William Cutler</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Bertha Muri</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>479 05 1298</b> <b>17. INFORMANT</b> <b>Edwin Paul Cutler, Takoma Park, Md.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> <b>4. 3. 1</b> <b>IMMEDIATE CAUSE (a)</b> <b>Acute myocardial infarction.</b> <b>Conditions, if any, which gave rise to immediate cause (b)</b> <b>(a), stating the underlying cause last.</b> <b>Coronary vascular disease</b> <b>DUE TO</b> <b>DUE TO</b> <b>(c)</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 days</b> <b>4 days</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>None</b> <b>19</b>		<b>20d. INJURY OCCURRED</b> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Sept 17, 1961</b> <b>to</b> <b>Sept 24, 1961</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>Sept 19, 1961</b> <b>and that death occurred at</b> <b>7:00 A.M.</b> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>ALFRED R. LAPP</b>		<b>22b. ADDRESS</b> <b>CLINTON, MD.</b> <b>22d. DATE SIGNED</b> <b>SEP 27 '61</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>burial</b>		<b>23b. DATE THEREOF</b> <b>9/25/61</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Huntt Funeral Home</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Immanuel Church Cemetery</b> <b>23d. LOCATION (City, town or county)</b> <b>Brandywine, Md.</b>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10526

10520

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Reside or before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Suitland Md</i>				c. LENGTH OF STAY IN 1b <i>41 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suitland Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Myrtle</i> Middle <i>C.</i> Last <i>Davidson</i>				4. DATE OF DEATH Month <i>Sept.</i> Day <i>16</i> Year <i>1961</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 19, 1917</i>	9. AGE (In years last birthday) <i>44</i> yrs.	IF UNDER 1 YEAR Months <i>44</i> Days <i>16</i> Hours <i>16</i> Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dr's Office</i>		11. BIRTHPLACE (State or foreign country) <i>North Dakota</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William Baker</i>				14. MOTHER'S MAIDEN NAME <i>Thelma Horst Meyer</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <i>Hillcrest Heights Md.</i> <i>Lloyd Davidson, 5017-26th Ave.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Lupus Erythematosus, disseminated</i> 705.5 DUE TO (b) <i>disseminated</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>15 months</i> INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May 7, 1961</i> , to <i>Sept. 16, 1961</i> , that (I) (we) last saw the deceased alive on <i>9-15-61</i> , and that death occurred at <i>6:25</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>David S. Gordon</i>				22b. DATE SIGNED <i>Sept. 16-61</i>			
22c. PHYSICIAN'S NAME (Type) <i>David S. Gordon</i>				22d. ADDRESS <i>5731 23d Parkway, Hillcrest Hts., Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9-19-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Catholic Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Hazelton North Dakota</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Sammons Bros.</i>				25a. REC'D BY REGISTRAR <i>1661-20th Ave NW WASH, 20 DC</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

(M)

(I)

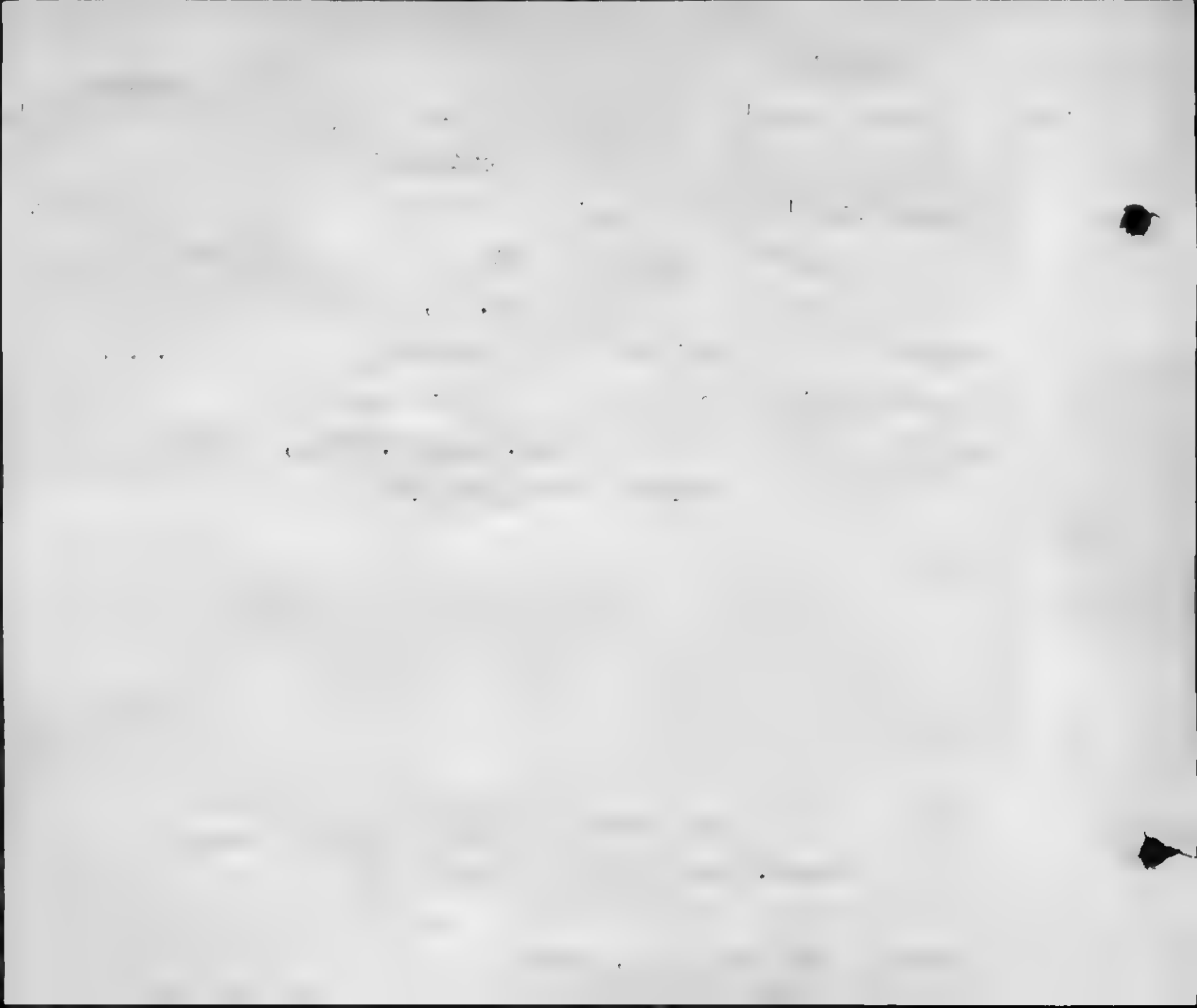
1



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10527 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, If institution, give name of institution, before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>5114-70th Place</b>			
3. NAME OF DECEASED (Type or print) <b>Joseph King Davis</b>				4. DATE OF DEATH <b>September 4 19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 18, 1890</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fisherman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Louis Davis</b>				14. MOTHER'S MAIDEN NAME <b>Mary Wilkerson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>17. INFORMANT <b>Mrs. Agnes G. Meyer, same as # 2</b></b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Carcinoma of the left lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MED. CAL EXAM. NER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>9/4/61</b> DATE SIGNED Address (Street, c'ty, town, or county)							
ACTUAL SIGNATURE <b>James I. Boyd</b>		EXAMINER'S NAME (Type) <b>James I. Boyd</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/6/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Joy Chapel</b>		22d. LOCATION (City, town, or country) (State) <b>Hollywood, Maryland</b>	
23. FUNERAL DIRECTOR <b>W. Clarke Mattingley</b>				24a. REC'D BY REGISTRAR <b>SEP 8 '61</b> 24b. REGISTRAR'S SIGNATURE <b>W. Clarke Mattingley</b>			
25. FUNERAL DIRECTOR ADDRESS <b>Leonardtwn, Maryland</b>				DATE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

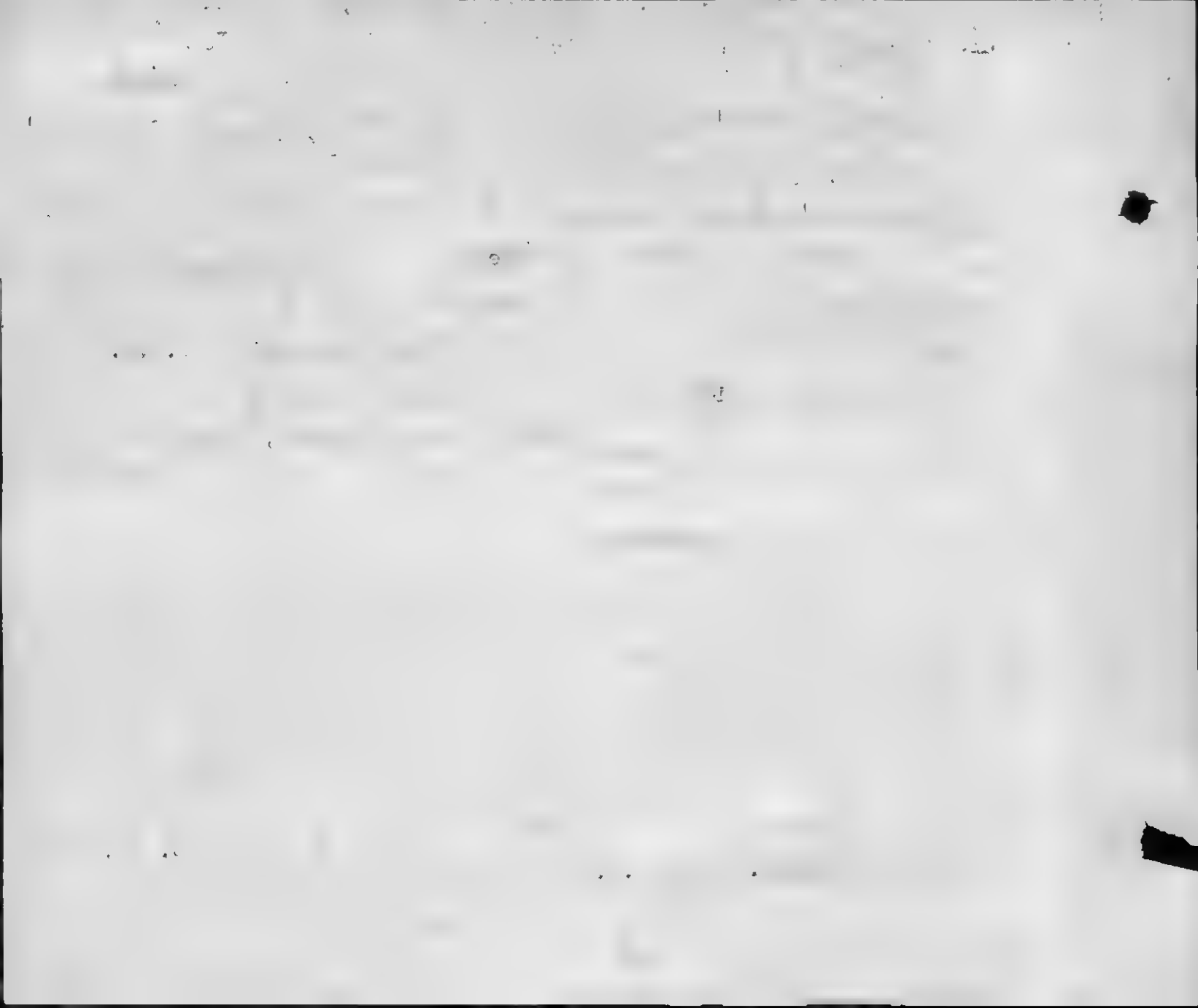
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10528 Item 23 Film 6297 10/2/61 10522											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN b <b>33 HOURS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>USAF HOSPITAL, ANDREWS AFB</b>						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DISTRICT OF COLUMBIA</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> d. STREET ADDRESS <b>2137 SUTLAND TERRACE SE</b>					
3. NAME OF DECEASED (Type or print) <b>CONNIE LOU DEESE</b>						4. DATE OF DEATH Month <b>Sept.</b> Day <b>20</b> Year <b>1961</b>					
5. SEX <b>FEMALE</b>						6. COLOR OR RACE <b>CAUCASIAN</b>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <b>18 SEPTEMBER 1961</b>					
9. AGE (in years last birthday) <b>33</b>						10. IF UNDER 1 YEAR Months <b>33</b> Days <b>33</b> Hours <b>33</b> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>					
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>						12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>					
13. FATHER'S NAME <b>MARVIN FARRELL DEESE</b>						14. MOTHER'S MAIDEN NAME <b>KO PU YONG</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give word or dates of service) <b>NO</b>						16. SOCIAL SECURITY NO. <b>NONE</b>					
17. INFORMANT <b>FATHER</b>						Address <b>SAME AS ITEM #2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Vasomotor &amp; Resp Collapse</b> <b>700.0</b> DUE TO <b>Chronic Hypoxia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause test. } DUE TO <b>Questionable Cerebral Anoxia 2° to Birth Trauma</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>20 Sept.</b> <b>1961</b> , to <b>20 Sept.</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>20 Sept.</b> <b>1961</b> , and that death occurred at <b>1318</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Wesley D. Stepp</b> M.D.											
22b. DATE SIGNED <b>20 Sept 61</b>											
22c. PHYSICIAN'S NAME (Type) <b>Wesley D. Stepp, CAPT USAF Hosp Andrews Maryland</b>											
22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>											
23b. DATE THEREOF <b>Sept. 22, 1961</b>											
23c. NAME OF CEMETERY OR CREMATORY <b>D. C. Morgue</b>											
23d. LOCATION (City, town or county) (State) <b>19 &amp; E. St., SE, Wash., D. C.</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>SEP 25 '61</b>											
25a. REC'D BY REGISTRAR <b>SEP 25 '61</b>											
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>											



VS. AISME  
5M 9/60

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PWS-3. Page 5 may be retained for your files.

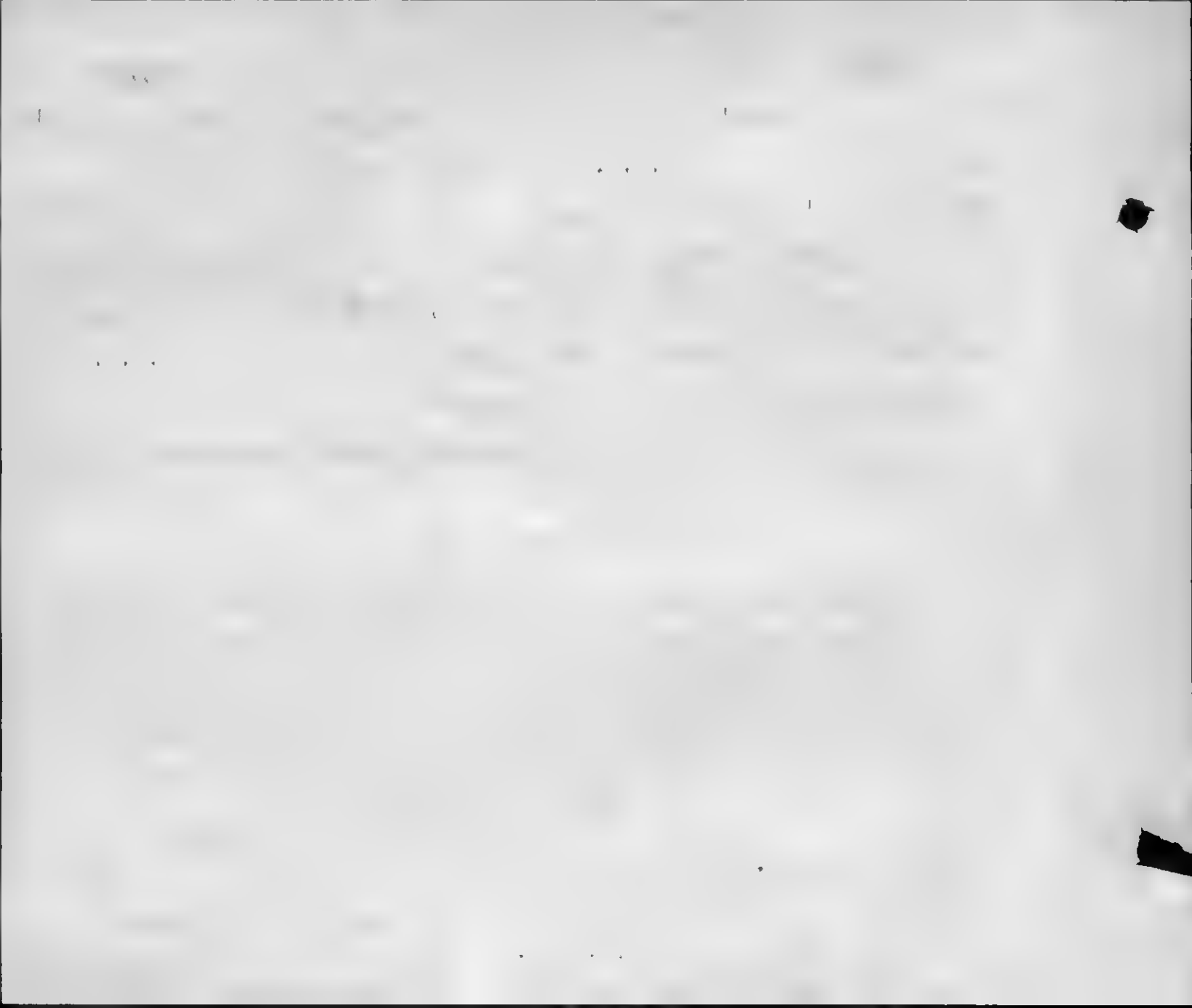
**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>Item 18 Film 297 10-2 MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>10530 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10524</div>											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>6807 F Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Francis Howard Dore</b>				4. DATE OF DEATH Month <b>September</b> Day <b>18</b> Year <b>1961</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 26, 1922</b>		9. AGE (In years last birthday) <b>39 yrs.</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>18</b> Hours <b>18</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Giant Foods</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles Dore Sr</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW 11</b>		17. INFORMANT <b>Mrs Betty Eileen Dore, same as # 2</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>872.9</b> DUE TO (b) <b>(Pending)</b> <b>Ingestion of Salicylates</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>-</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) <b>-</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>9/18/61</b>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				Address (Street, city, town, or county) <b>Ft Myer Va</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/21/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington</b>		22d. LOCATION (City, town, or country) <b>Ft Myer</b>		22e. REC'D BY REGISTRAR <b>SEP 20 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	
23. FUNERAL DIRECTOR <b>Lee Funeral Home, 300 4th N.E. Wash. D.C.</b>				ADDRESS							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

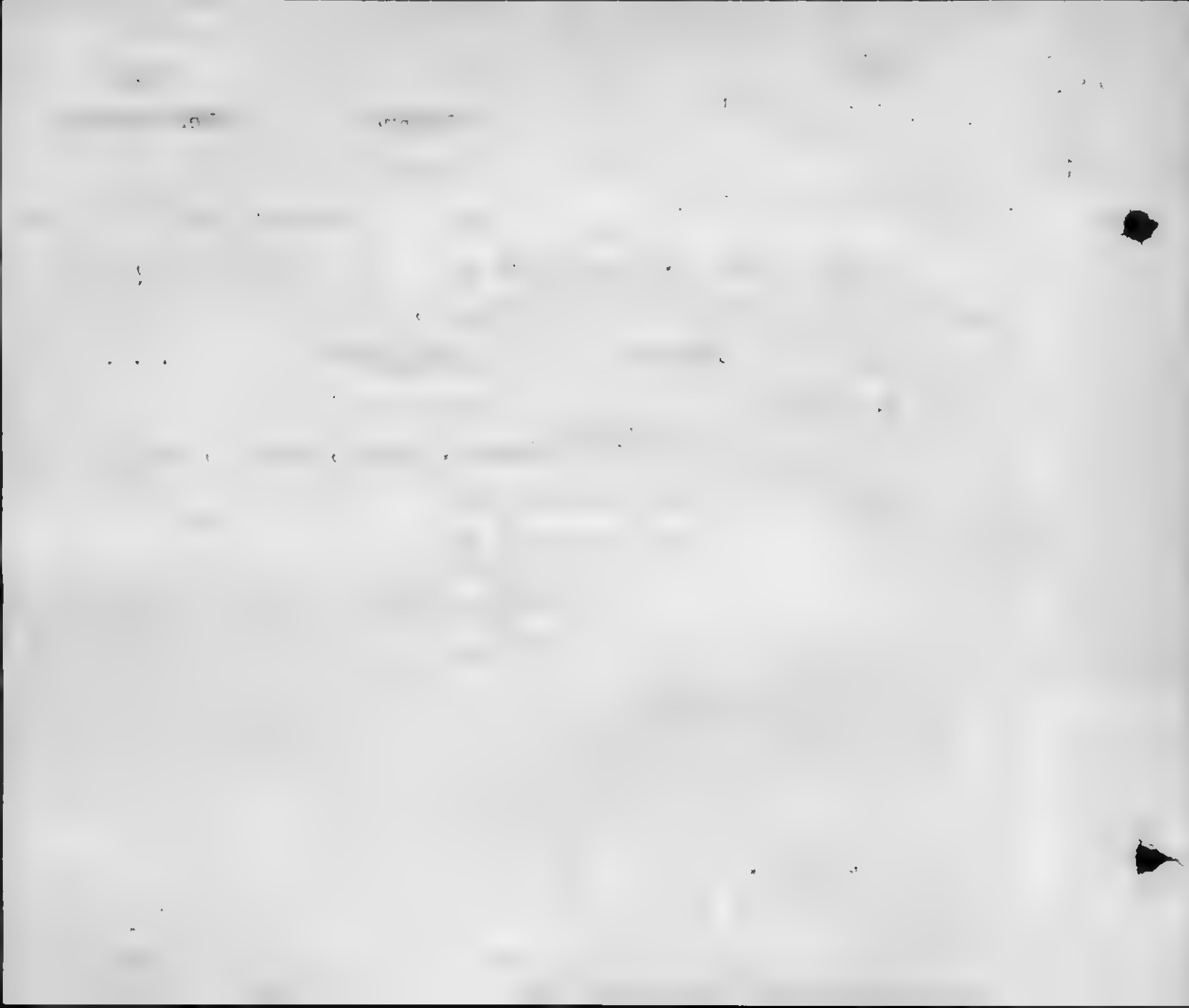
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MEDICAL CERTIFICATION

VS. A15ME  
5M 9,60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10531 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10525											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if inst. funeral, residence before adm.) a. STATE <b>Delaware</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <b>Dover</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>						c. LENGTH OF STAY IN TB <b>1 hour</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frederick Charles Dowd Jr</b>						4. DATE OF DEATH Month Day Year <b>September 23, 1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 27, 1900</b>		9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>				11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred E. Dowd</b>						14. MOTHER'S MAIDEN NAME <b>Alexinia Smith</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>064-18-6639</b>					
17. INFORMANT <b>Roland P. Trader, Dover, Delaware</b>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary artery disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>9/24/61</b>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9-27-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>West View Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Atlanta, Georgia</b>			
23. FUNERAL DIRECTOR <b>W.W. Chambers</b>				ADDRESS <b>5801 Cleveland Ave, Riverdale, Md</b>				24. REC'D BY REGISTRAR <b>SEP 27 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

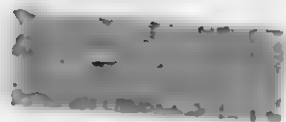


10532

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Reside in institution) o STATE <i>Md.</i> b. COUNTY <i>H.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Sacred Heart Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Eleanor</i> Middle <i>Mary</i> Last <i>Duke</i>		4. DATE OF DEATH Month <i>September</i> Day <i>7</i> Year <i>19 61</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-13-1872</i>
9. AGE (In years last birthday) <i>89</i> yrs.		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>10</i> Hours <i>10</i> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph J. Turner</i>		14. MOTHER'S MAIDEN NAME <i>Virginia Mumford</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Sacred Heart Home, Hyattsville, Md.</i>	
17. INFORMANT <i>Sacred Heart Home, Hyattsville, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY THROMBOSIS &amp; MYOCARDIAL INFARCTION</i> DUE TO (b) <i>ARTERIOSCLEROTIC HEART DISEASE</i> DUE TO (c) <i>DIABETES MELLITUS</i> INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i> <i>8 years</i> <i>10 years</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>PAGEY'S DISEASE</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <i>9-1</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9-1</i> , 19 <i>61</i> , to <i>9-7</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>9-7</i> , 19 <i>61</i> , and that death occurred at <i>12</i> M., from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas F Collins</i>		22b. DATE SIGNED <i>9-7-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>THOMAS F COLLINS</i>		22d. ADDRESS <i>355 H. H. N.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>9-11-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		25a. REC'D BY REGISTRAR <i>SEP 13 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			



may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

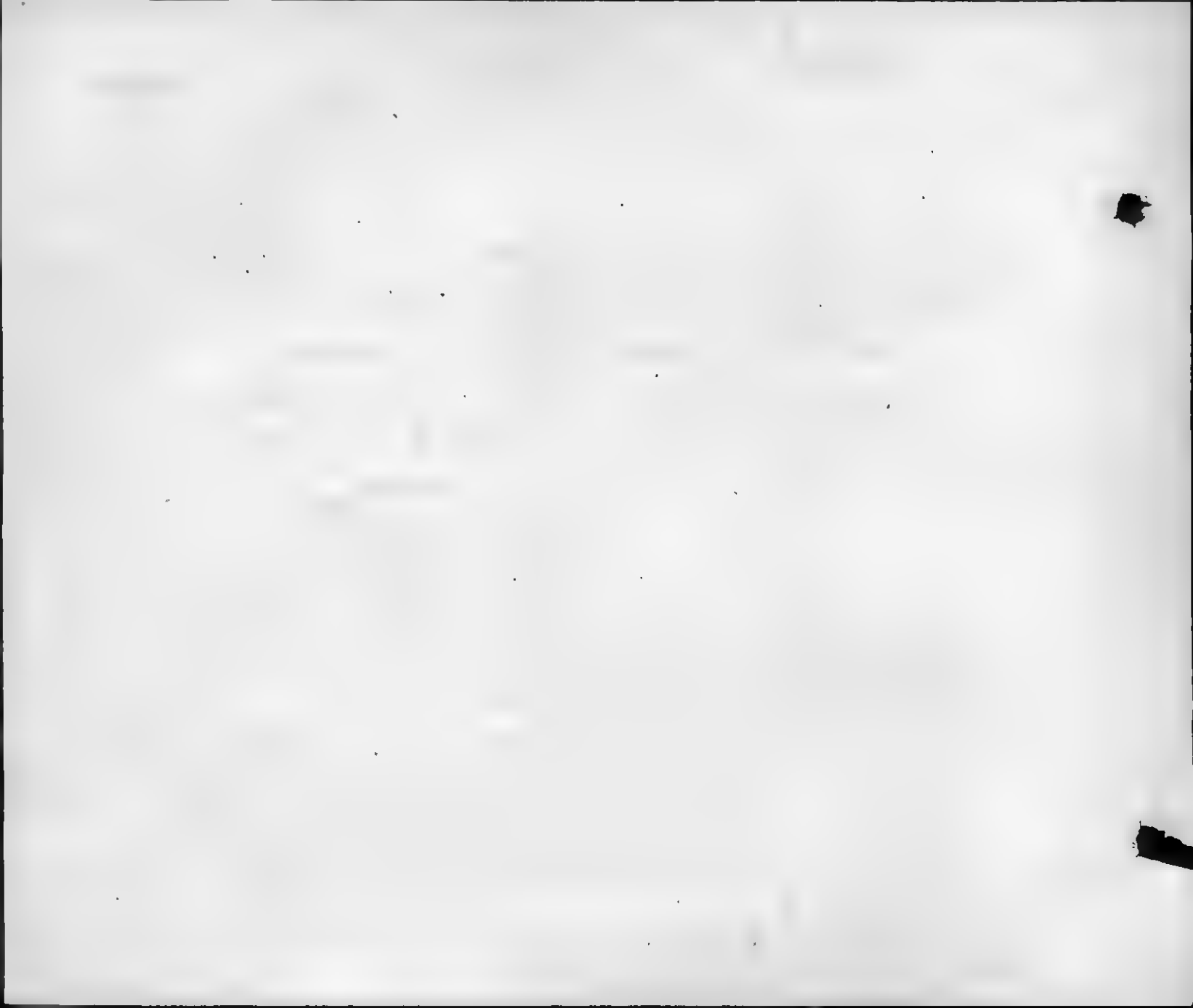
10533

Item 0 Film 0297 10/3/61 mh

10527

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pr. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Morningside</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince George's Gen. Hospital</i>		d. STREET ADDRESS <i># 7 - Beauford Rd SE</i>	
3. NAME OF DECEASED (Type or print) First <i>NORMA</i> Middle <i>V</i> Last <i>Eberle</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>27</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1890</i>
9. AGE (In years last birthday) <i>70</i> yrs		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>17</i> Hours <i>17</i> Min.	11. IF UNDER 24 HRS Months <i>7</i> Days <i>17</i> Hours <i>17</i> Min.
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>HARVEY L. BAHR</i>		14. MOTHER'S MAIDEN NAME <i>Annie M. Edwards</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <i>578-12-2947</i>	
17. INFORMANT <i>Kenneth A. Eberle</i>		Address <i>Same as # 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>413X Azotemia - Severe</i> DUE TO (b) <i>Chronic Pyelonephritis</i> DUE TO (c) <i>Hypertensive arteriosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <i>2 wks. 6-8 yrs. 10 yrs.</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 19</i> to <i>Sept 27</i> , 19 <i>61</i> that (I) (we) last saw the deceased alive on <i>Sept 26</i> , 19 <i>61</i> , and that death occurred at <i>11</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Sidney W. Lowery</i>		22b. DATE SIGNED <i>Sept 27, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>Sidney W. Lowery</i>		22d. ADDRESS <i>7200 Marlboro Pike SE District of Columbia</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>9-30-61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Washington Natl</i>	23d. LOCATION (City, town, or county) (State) <i>Southland Md</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>James Bros.</i>		25a. REC'D BY REGISTRAR <i>SEP 29 '61</i>	
ADDRESS <i>1661 - Good Hope Rd SE Wash DC</i>		25b. REGISTRAR'S SIGNATURE <i>Clayton L. Hume</i>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

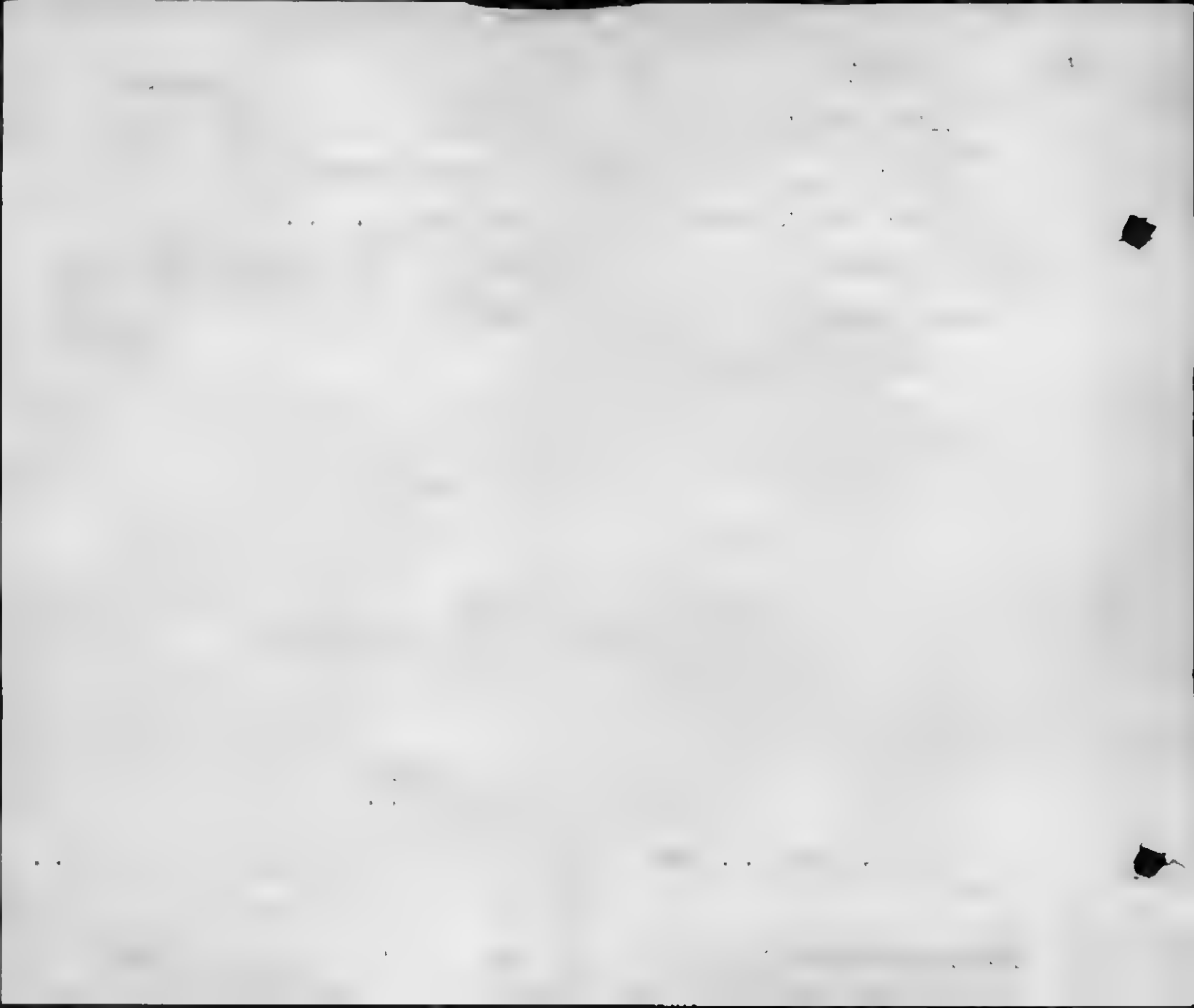
## CERTIFICATE OF DEATH

10534

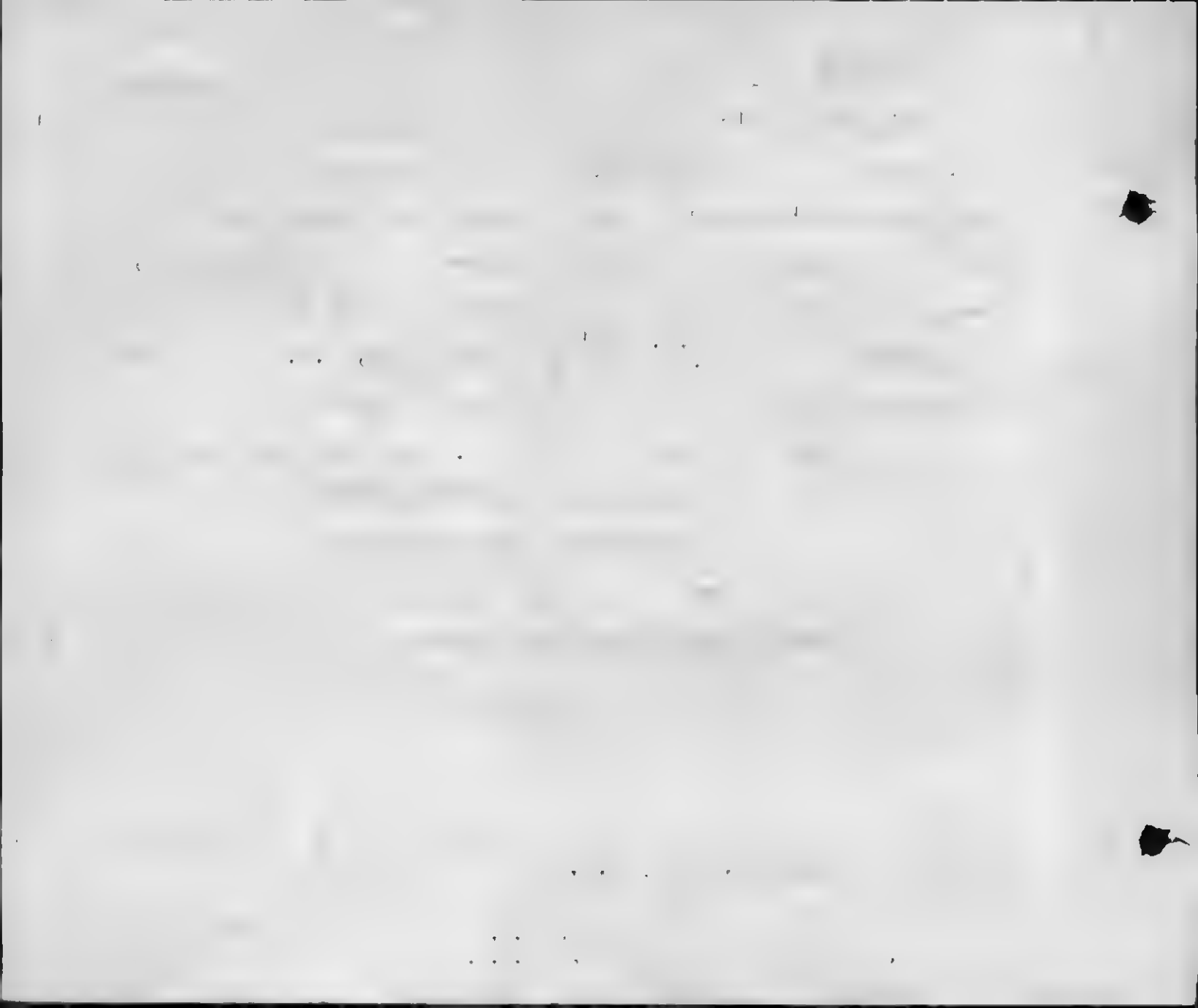
10528

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN b. <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fairmont Heights</u> d. STREET ADDRESS <u>716 61st Ave. N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Robert</u> First Middle Last <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>Colored</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>4. DATE OF DEATH</b> <u>September 28, 1961</u> Month Day Year <b>8. DATE OF BIRTH</b> <u>6/5/96</u> Months Days Hours Min. <b>9. AGE</b> (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>N.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Unknown</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Bond</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes give year or dates of service) <u>yes WW#</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>Evie Ellis</u> Address <u>716 61st Ave N.E.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> Conditions, if any, which gave rise to immediate cause (b) <u>Hypertens. Arsk. Sclerosis Ht dis.</u> (c), stating the underlying cause last. <u>DIABETES MELLITUS</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>Sep 26</u> to <u>Sep 28</u>, 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>Sep 28</u>, 19<u>61</u>, and that death occurred at <u>6:25</u>, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Samuel J. N. Sugar</u> M.D.		<b>22b. DATE SIGNED</b> <u>SEP 28 1961</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type or print) <u>Dr. Samuel J. N. Sugar</u>		<b>22d. ADDRESS</b> <u>4637 Eastern Avenue, Washington 18, D.C.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>10-4-61</u>		<b>23b. DATE THEREOF</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Nat.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Arlington Va</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Henry S. Washington</u>		<b>25a. REC'D BY REGISTRAR</b> <u>4925</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>NE</u>		<b>25c. DATE</b> <u>OCT 4 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

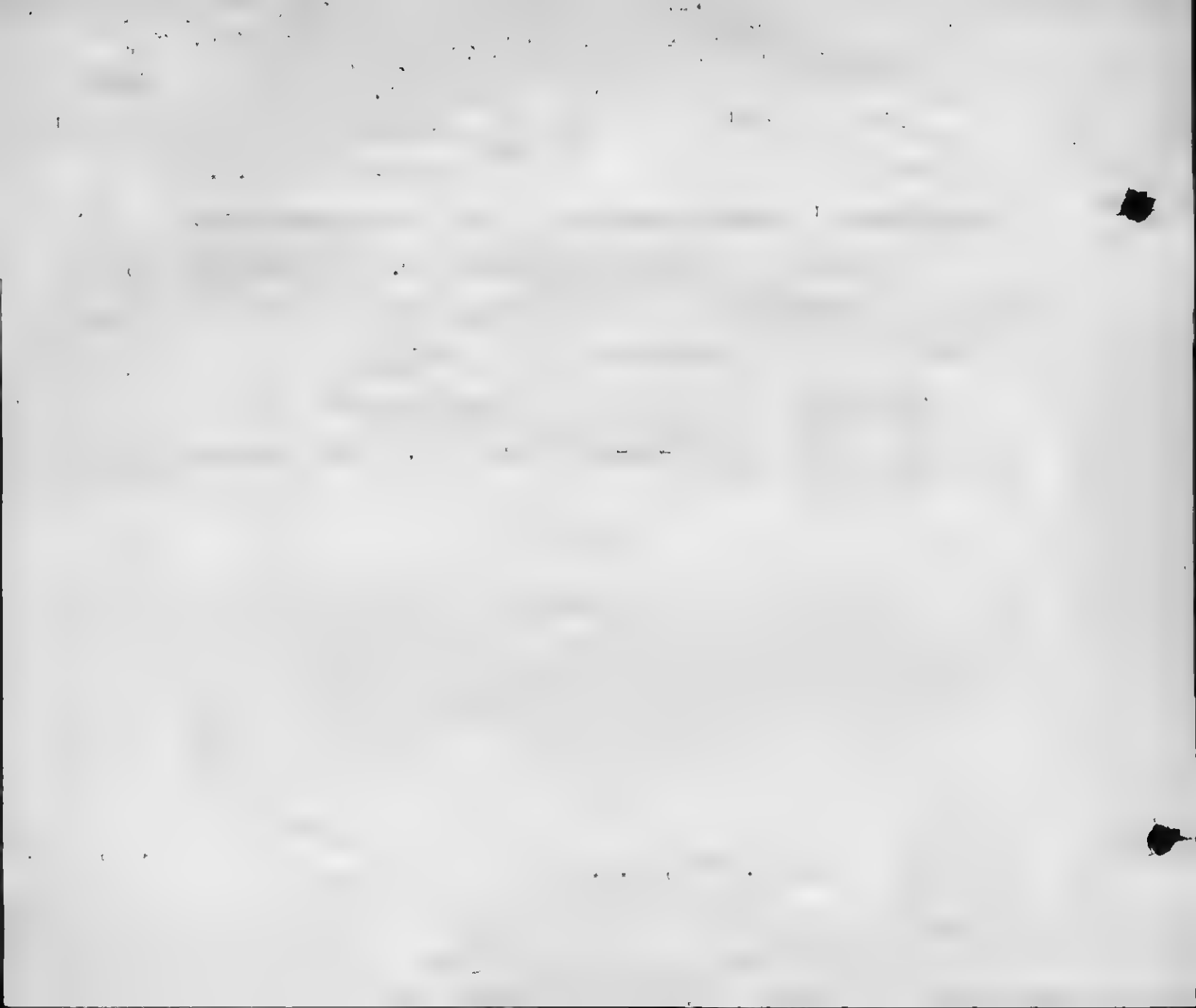
## 10536 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10530

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Res. date before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb. <b>Washington, 28 D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. STREET ADDRESS <b>7340 Walker Mill Road</b>	
3. NAME OF DECEASED (Type or print) <b>Conrad Elmer Faunce, Sr.</b>	4. DATE OF DEATH <b>September 8, 1961</b>	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 10, 1906</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	9. AGE (In years last birthday) <b>55</b> yrs.	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Conrad Faunce</b>	14. MOTHER'S MAIDEN NAME <b>Emma Goddard</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>577-03-8846</b>	17. INFORMANT <b>Baulah M. Faunce Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INFARCT, HEART</b> DUE TO <b>SEVERE, OCCLUSIVE CORONARY ATHEROSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1201</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>9-11-1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or country) (State) <b>Suitland Md</b>
23. FUNERAL DIRECTOR <b>Gober A. Mattingly</b>	ADDRESS <b>Wash 3 D.C.</b>	24a. REC'D BY REGISTRAR <b>SEP 13 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

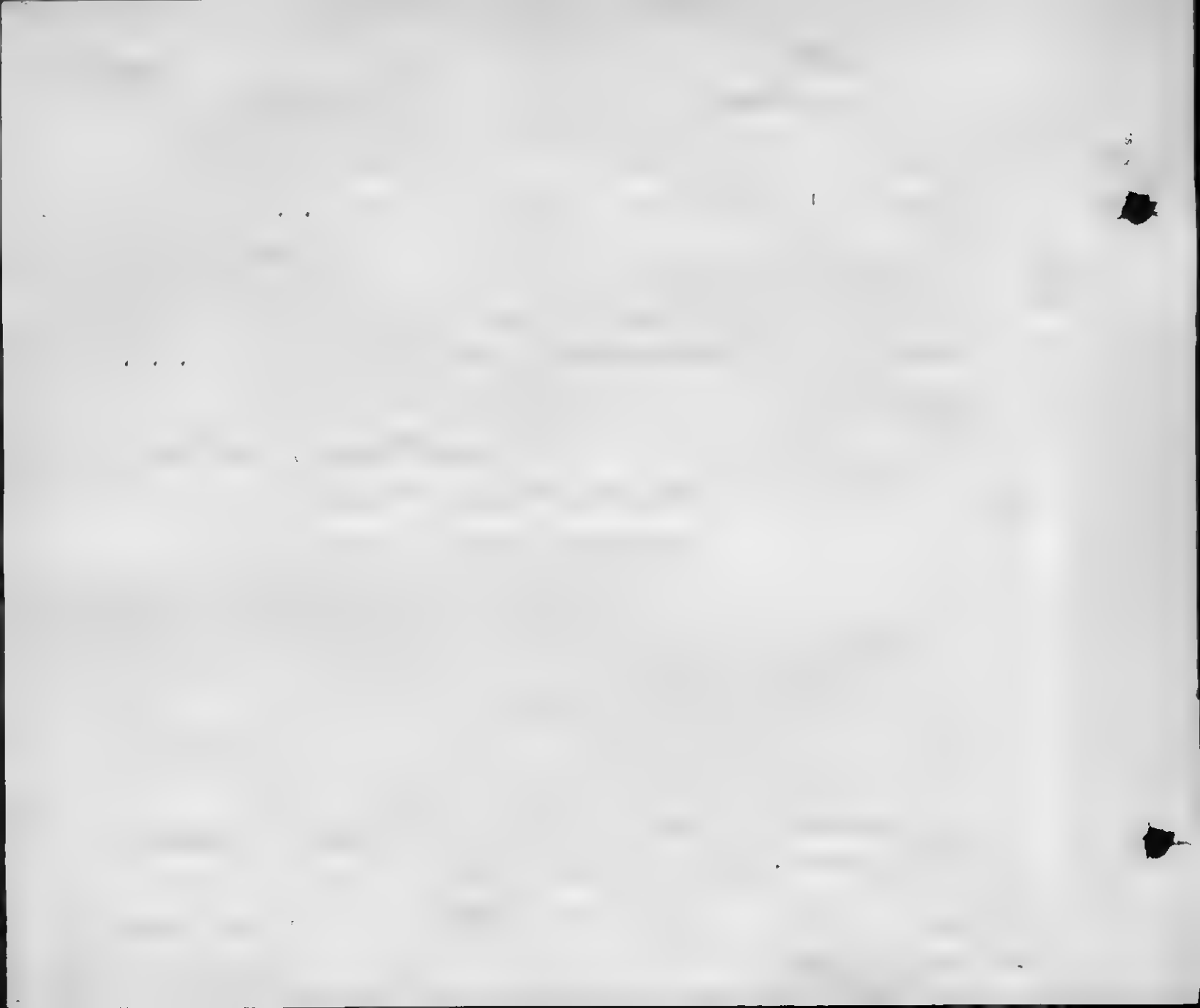
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10537 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10531											
1. PLACE OF DEATH a. COUNTY Prince George's				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 1326 G Street N.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alonza Ferguson				4. DATE OF DEATH Sept 19 1961							
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Construction				11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO.				17. INFORMANT Mrs Mamie Ferguson, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 4-12X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease. (c) DUE TO (e), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 9/19/61			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/23/1961		22c. NAME OF CEMETERY OR CREMATORY Calvary Baptist Church		22d. LOCATION (City, town, or country) Farmville, Virginia			
23. FUNERAL DIRECTOR Alex S. Pope				ADDRESS 414 15th. St. S. E.				24a. REC'D BY REGISTRAR DATE SEP 21 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10538

10532

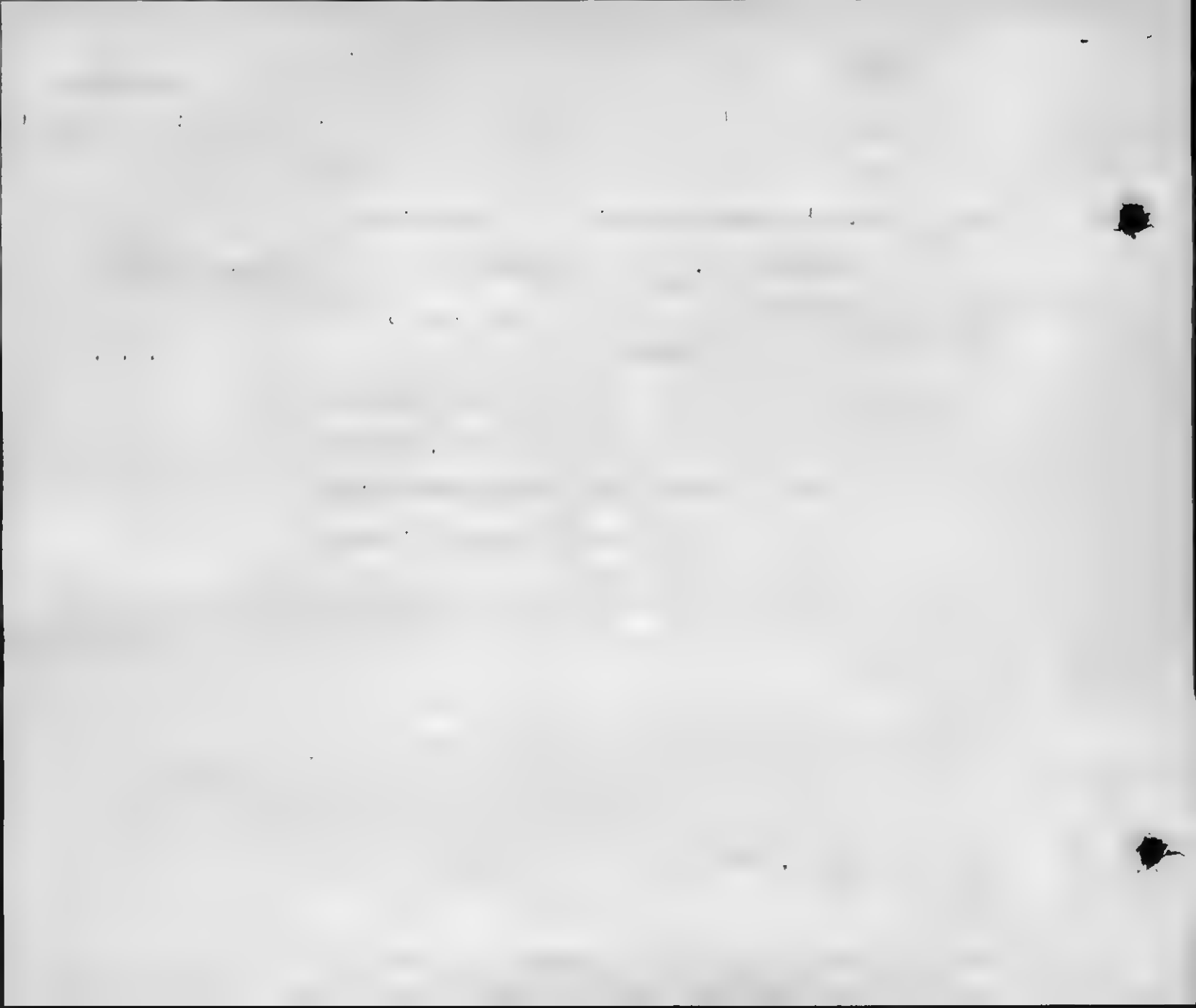
<b>1. PLACE OF DEATH</b> a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY (If in hospital, give street address) <b>7 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>US AIR FORCE HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DISTRICT OF COLUMBIA</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> d. STREET ADDRESS <b>2427 ALABAMA AVENUE</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>ALESSANDRA CAROL FRANCIS</b>		<b>4. DATE OF DEATH</b> Month <b>SEPTEMBER</b> Day <b>18</b> Year <b>1961</b>		<b>5. SEX</b> <b>FEMALE</b> <b>6. COLOR OR RACE</b> <b>NEGRO</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>NONE</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>NONE</b>		<b>8. DATE OF BIRTH</b> <b>10 SEPTEMBER 1961</b> yrs. <b>7</b> Months <b>7</b> Days <b>7</b> Hours <b>15</b> Min.		<b>9. AGE</b> (In years, last birthday) <b>5</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>UNITED STATES</b>			
<b>13. FATHER'S NAME</b> <b>MILLARD MURRAY FRANCIS</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>AUDREY WAGNER</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)			
<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> <b>HOSPITAL CHART</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Primary Pulmonary Atelectasis</b> DUE TO <b>Immaturity</b> Conditions, if any, which gave rise to immediate cause (b) <b>7 days</b> (c) <b>7 days</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>			
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10 SEPT. 1961</b> to <b>18 SEPT. 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>18 SEPT. 1961</b> , and that death occurred at <b>5:15 A.M.</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <i>Nicholas P. Haritos</i>		<b>22b. DATE SIGNED</b> <b>18 SEPT 61</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>NICHOLAS P HARITOS, Capt USAF MC</b>			
<b>22d. ADDRESS</b> <b>USAF HOSP, ANDREWS AFB, WASH 25 DC</b>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b> <b>23b. DATE THEREOF</b> <b>9-20-61</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ARLINGTON NATIONAL</b> <b>23d. LOCATION</b> (City, town or county) <b>ARLINGTON VA.</b> (State)					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>B. F. Taylor</i>		<b>25a. REC'D BY REGISTRAR</b> <b>SEP 21 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Harris</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60



Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

10534

1. PLACE OF DEATH  
a. COUNTY Prince George's MARYLAND  
b. CITY OR TOWN (if out of corporate limits write RURAL and give nearest town) Chegerly  
c. LENGTH OF STAY IN IL 1 day  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE Maryland b. COUNTY Prince George's  
c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Hyattsville  
d. STREET ADDRESS 4503 Burlington Rd.,

3. NAME OF DECEASED (Type or print) Jessie Gallaher  
First Middle Last

4. DATE OF DEATH September 11 19 61  
Month Day Year

5. SEX Female 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 8-8-11  
9. AGE (in years last birthday) 50 yrs. 11 months 11 days 61 hours 19 min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Drug Store 11. BIRTHPLACE (County & State, or foreign country) West Virginia 12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Walter Gorden 14. MOTHER'S MAIDEN NAME Lydia Raynolds

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. no 17. INFORMANT Lydia Gorden Address Hyattsville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Carcinomatosis  
171X DUE TO Ca of Cervix  
Conditions, if any, which gave rise to immediate cause (b) 2 yrs  
(e), stating the underlying cause last. DJE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

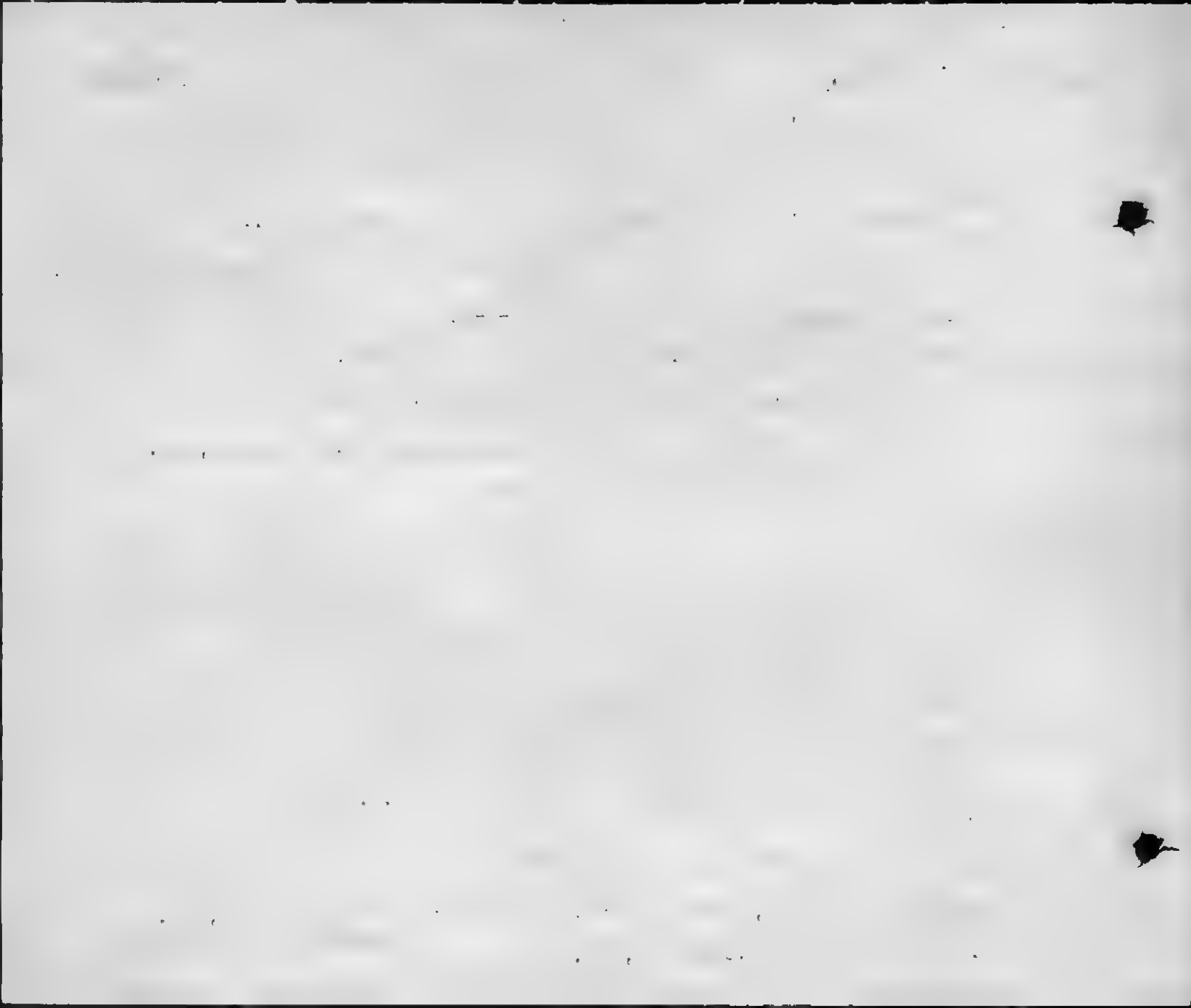
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  
20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  
20f. (City or town) (County) (State)

21. I certify that (I) (th) s hospital attended the deceased from 10 years to 19, that (I) (we) last saw the deceased alive on 9-11 19 61 and that death occurred at 5:50 P.M. from the causes and on the date stated above.

22a. SIGNATURE Dayton O Watkins M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED  
22c. PHYSICIAN'S NAME (Type) DAYTON O WATKINS 22d. ADDRESS 6318 Annapolis Rd  
Bladensburg Md (State)

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Sept 14, 1961 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery 23d. LOCATION (City, town or county) (State) Colmar Manor, Md.

24. FUNERAL DIRECTOR'S SIGNATURE A. Gasch's Sons ADDRESS Hyattsville, Md. 25a. REC'D BY REGISTRAR SEP 15 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hanes



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

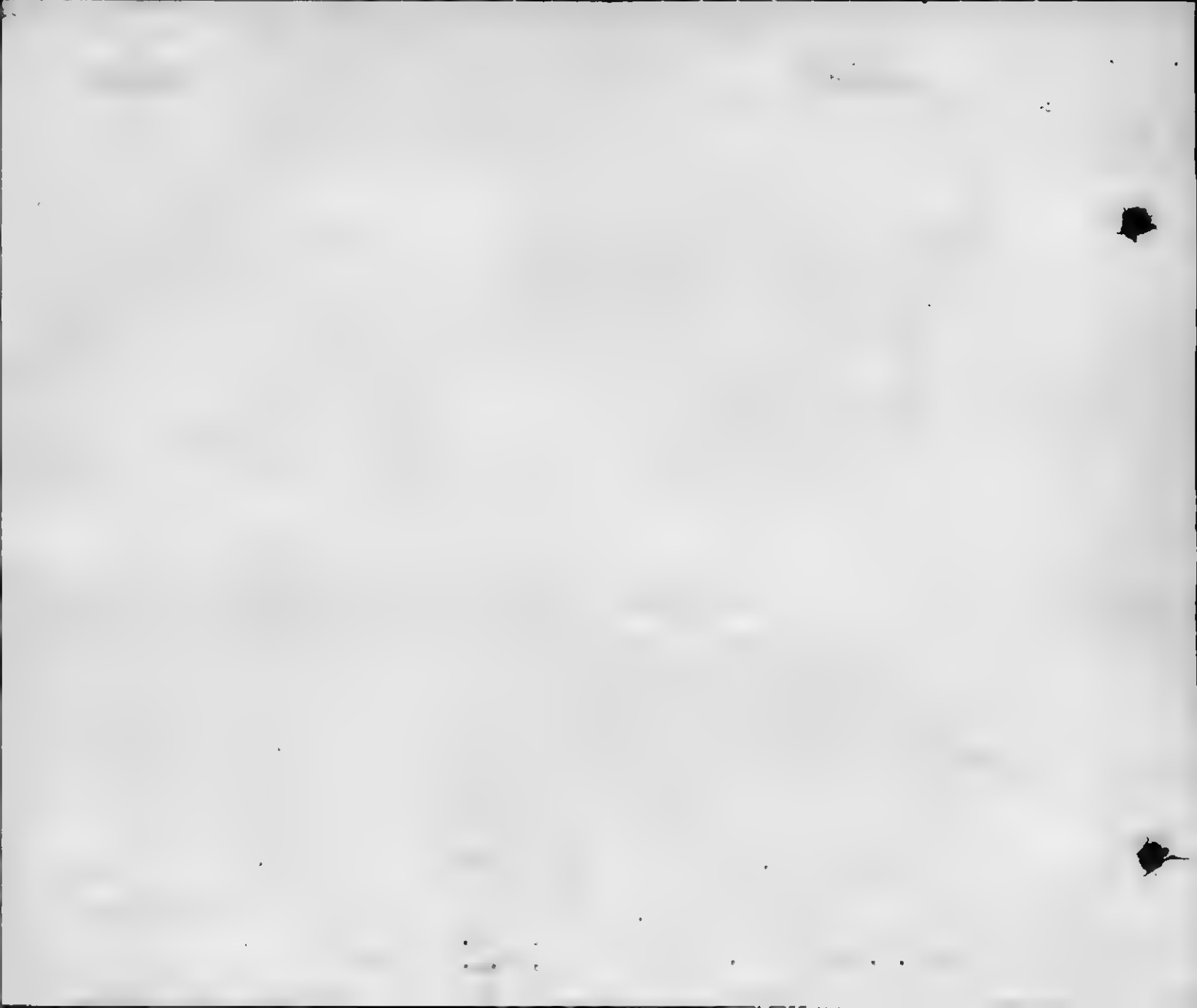
10541

10535

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5909 Taylor Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> d. STREET ADDRESS <u>5909 Taylor Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Sherman</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>25</u> Year <u>1961</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1872</u>	9. AGE (in years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Brainerd, Minn.</u>			
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT (Print name) <u>Mrs Dorothy M. Frank</u> Address <u>5909 Taylor Rd. Riverdale, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c) <u>Gangrene of leg with amputation</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>7-10 days</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. We certify that <u>we (this hospital)</u> attended the deceased from <u>9-3</u> , 19 <u>61</u> to <u>9-24</u> , 19 <u>61</u> , that <u>(X)</u> we last saw the deceased alive on <u>9-22</u> , 19 <u>61</u> , and that death occurred at <u>12:28</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Ronald E. Krum MD</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Ronald E. Krum</u>				22d. ADDRESS <u>8904 2nd Lanham, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>9/27/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>			
23d. LOCATION (City, town or county) <u>Prince Georges County, Md.</u>		23e. REC'D BY REGISTRAR <u>Arthur S. Krum</u>		23f. REGISTRAR'S SIGNATURE			
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington 9, D.C.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH

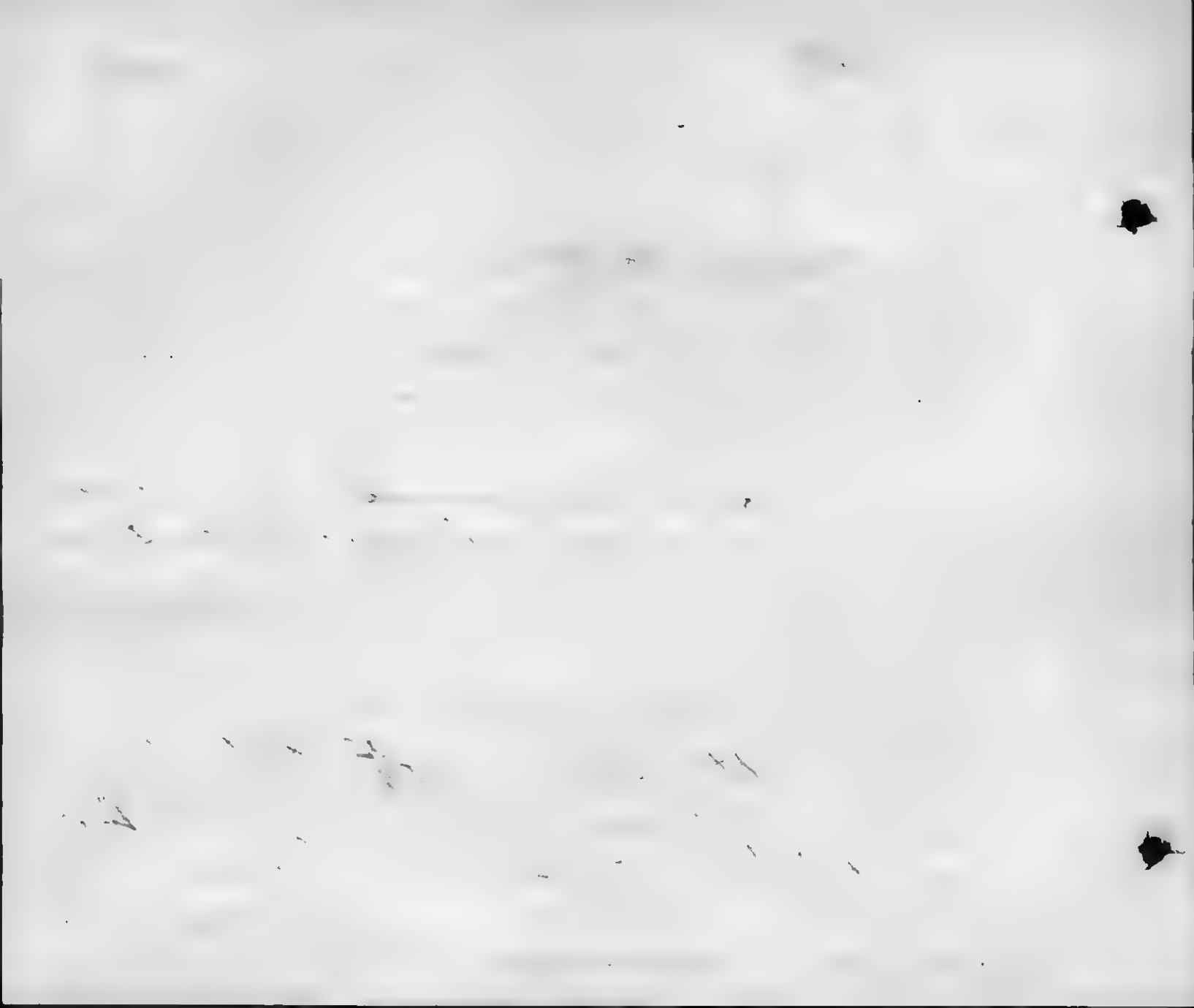
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10542

10536

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Madison Manor Nursing Home</u> <u>5801 42nd Ave</u> First Middle Last		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u> d. STREET ADDRESS <u>Enterprise Road</u> Last First Middle e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Marguerite A. Gauthier</u>		<b>4. DATE OF DEATH</b> Sept. 4 1961 Month Day Year	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>June 26, 1885</u>
<b>9. AGE</b> (In years last birthday) <u>76</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days	<b>11. IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>France</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>I Unk.</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Louise Cotin</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO</b> <u>none</u>	
<b>17. INFORMANT</b> <u>Patients Record</u>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>General paresis</u> <u>025 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>General arterio sclerosis</u> (b) (c)		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>7 mo.</u> <u>5 mo.</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part I of Item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. City or town</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept 1, 1961</u> <b>to</b> <u>Sept 4, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Sept 1, 1961</u> , <b>and that death occurred at</b> <u>5 PM</u> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>L W Malin</u>		<b>22b. DATE SIGNED</b> <u>9-4-61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>L W Malin MD</u>		<b>22d. ADDRESS</b> <u>Riverdale Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>9/7/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Colmar Manor, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F. Gasch's Sons</u>		<b>25a. REC'D BY REGISTRAR</b> <u>SEP 8 '61</u>	
<b>ADDRESS</b> <u>Hyattsville, Maryland</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Hanna</u>	



## CERTIFICATE OF DEATH

Reg. Dis. No. 10537

10543

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College PARK</u>				c. LENGTH OF STAY IN 1b <u>10 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9701 NARRAGANSETT PKwy</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Emily Gertrude Gleason</u>				4. DATE OF DEATH <u>September 18 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1915</u>	9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Montreal, Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Apperti</u>				14. MOTHER'S MAIDEN NAME <u>Jean Lombardi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-03-5993</u>		17. INFORMANT <u>Husband: Everett Gleason</u> Address <u>- Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced Metastatic Cancer</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Breast</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 + yrs.</u> <u>3 1/2 + yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	
				20f. (City or town) <u>-</u>		(County) (State)	
21. I certify that I attended the deceased from <u>August, 1961</u> , to <u>Sept. 18, 1961</u> , that I last saw the deceased alive on <u>Sept. 15, 1961</u> , and that death occurred at <u>4:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Fredrick Barr</u> M.D.				ADDRESS (Street, city or town, state) <u>4500 College Ave, College Park, Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. Frederick BARR, M.D.</u>				DATE SIGNED <u>9-18-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/21/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u> ADDRESS <u>mt. Rainier Md.</u>				24a. REC'D BY REGISTRAR <u>20'61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hauer</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

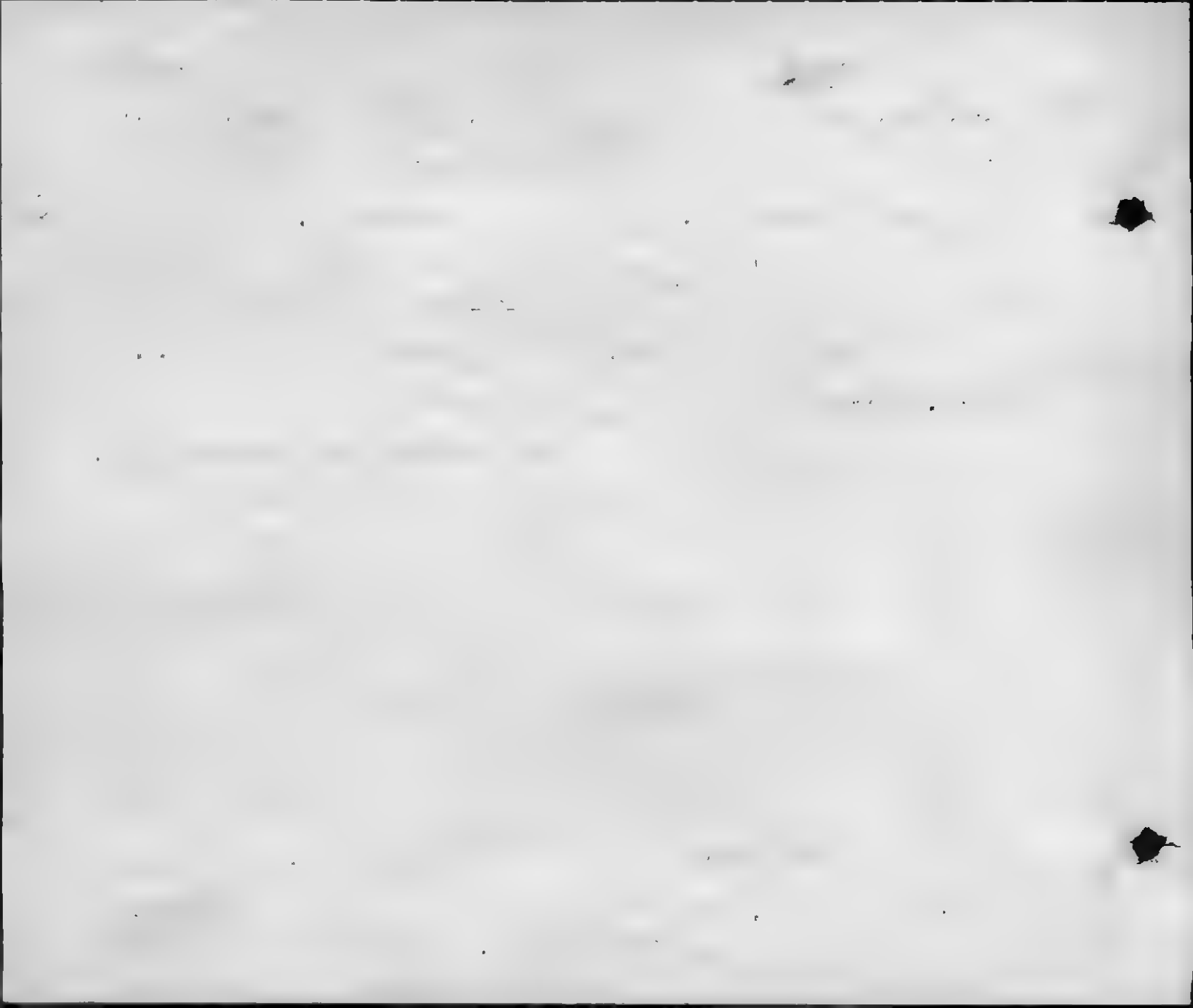
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10544

10538

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Eugene Leland Memorial Hosp.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>8502 Nicholson St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Ethel</b> First Middle Last <b>Graves</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>9 14 1961</b>	
<b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>4-30-1876</b> <b>9. AGE</b> (In years last birthday) <b>85</b> yrs. IF UNDER 1 YEAR: Months Days Hours M'n.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>own home</b>		<b>11. BIRTHPLACE</b> (County & State or foreign country) <b>Kentucky</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	
<b>13. FATHER'S NAME</b> <b>John L. Thurmond</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Martha ?</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>Mrs Lorene Little</b> Address <b>Hyattsville Md.</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-Pneumonia, Rt. Lung.</b> (b) <b>Advanced Arterio-Sclerosis</b> (c) <b>4 days</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that</b> (If this hospital attended the deceased from <b>May 1958</b> to <b>14 Sept., 1961</b> , that (b) (we) last saw the deceased alive on <b>13 Sept., 1961</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Thomas M Hutchins</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>Thomas M Hutchins</b>		<b>22b. DATE SIGNED</b> <b>14 Sept. 1961</b> <b>22d. ADDRESS</b> <b>Landover, Md.</b>	
<b>23a. BURIAL, CREMATION REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>Sept 18, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Oakwood Cemetery</b> <b>23d. LOCATION</b> (City, town or county) (State) <b>Macon Missouri</b>	
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>Baschi Funeral Home</b> ADDRESS <b>Hyattsville, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE SEP 18 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10545

## CERTIFICATE OF DEATH

11740

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>708 Washington Blvd</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md</u> b. COUNTY <u>Pr George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> d. STREET ADDRESS <u>708 Wash Blvd</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Virginia Maude Griffith</u> <b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>April 7, 1889</u> <b>9. AGE</b> (If years last birthday) <u>72</u> yrs. <b>10. AGE</b> (If under 1 year) <u>72</u> months <b>11. AGE</b> (If under 24 hrs.) <u>72</u> hours		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u> <b>13. FATHER'S NAME</b> <u>William A. Krieg</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Virginia Baugois</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO</b> (If yes give war or dates of service) <u>no</u>		<b>17. INFORMATION</b> Address <u>1005 Plaza St</u> <u>Mrs Grace F. Felling Clearwater Fla.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>196.1</u> DUE TO <u>Chronic Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Osteogenic Sarcoma Left Femur</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8-10 Mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (the hospital) attended the deceased from</b> <u>May 1961</u> <b>to</b> <u>Sept 30, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Sept 30, 1961</u> , <b>and that death occurred</b> <u>Sept 30, 1961</u> <b>M, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Robert C. Wingfield</u> <b>M.D.</b>		<b>22b. DATE SIGNED</b> <u>Sept 30, 1961</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>ROBERT C. WINGFIELD</u>		<b>22d. ADDRESS</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>10/3/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Natl</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Arlington, Va.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>De Witt Sanderson</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Arthur S. Kraus</u>	
<b>25b. REGISTRAR'S SIGNATURE</b>		<b>DATE</b> <u>OCT 9 '61</u>	

M

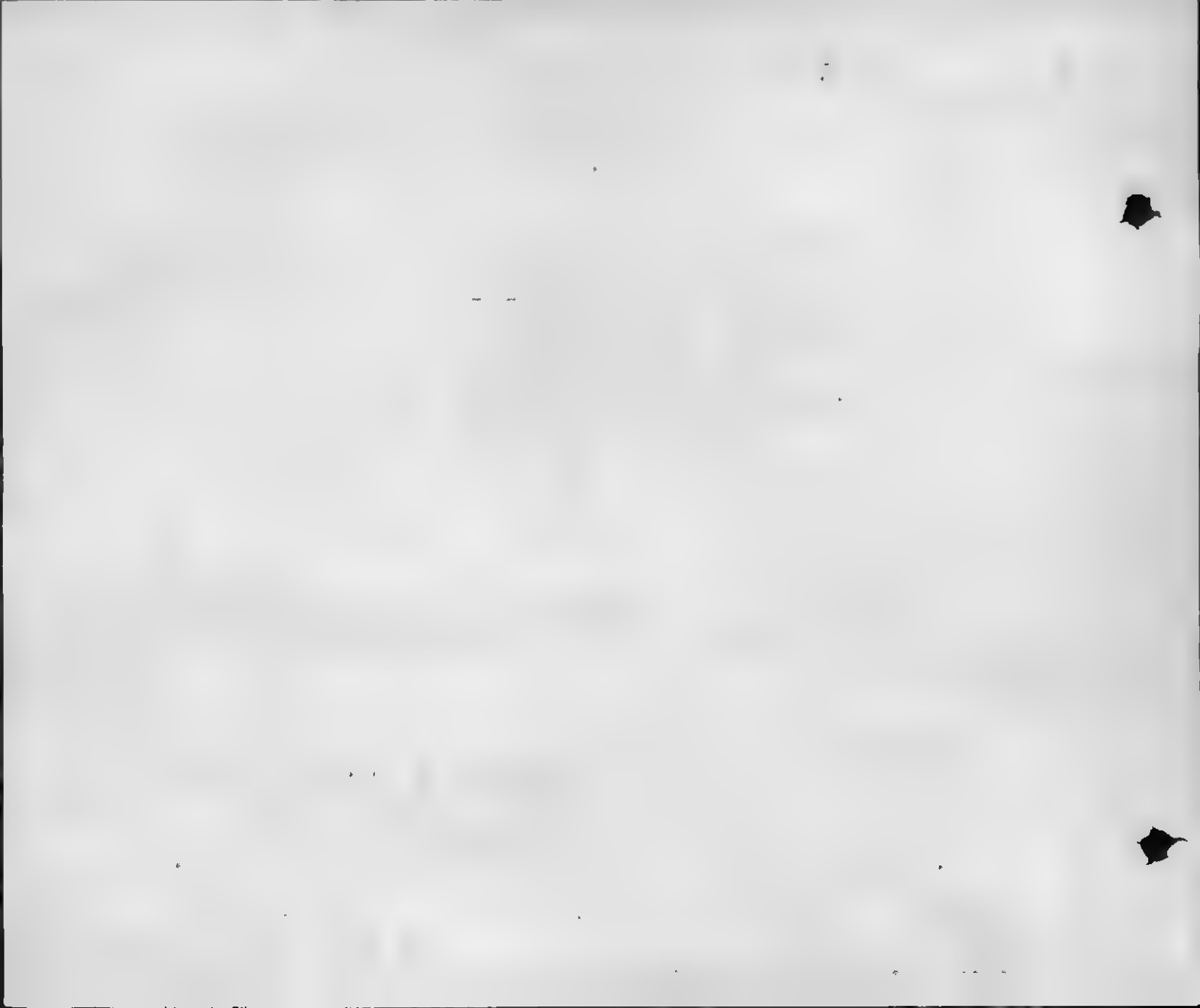
I

MEDICAL CERTIFICATION



2000

YR A15 (4)  
15M 9/60



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is not known, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND									
10547 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b>				
c. LENGTH OF STAY IN 1b <b>D.O.A.</b>					d. STREET ADDRESS <b>4006 Utah Avenue</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Cheryl Ann Hammond</b>					4. DATE OF DEATH Month <b>September</b> Day <b>23</b> Year <b>1961</b>				
5. SEX <b>Female</b>					6. COLOR OR RACE <b>White</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>					8. DATE OF BIRTH <b>July 3, 1961</b>				
9. AGE (In years last birthday) <b>2</b> yrs. <b>20</b> Months <b>0</b> Days <b>0</b>					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				
10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>					11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					13. FATHER'S NAME <b>James Wados Hammond</b>				
14. MOTHER'S MAIDEN NAME <b>Ann Marie Kaske</b>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT <b>James Wados Hammond, same as # 2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>493K</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>James I. Boyd</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>James I. Boyd</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					22b. DATE THEREOF <b>9/25/61</b>				
22c. NAME OF CEMETERY OR CREMATORY <b>W.W. Chambers Co. Riverdale Md.</b>					22d. LOCATION (City, town, or country) (State) <b>Littland Md.</b>				
24a. REC'D BY REGISTRAR <b>SEP 26 '61</b>					24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, at its designated office, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10548

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10540

1. PLACE OF DEATH

a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Comodory Hills

c. LENGTH OF STAY IN 1b

3 years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

412 Comodory Hills Lane

3. NAME OF DECEASED (Type or print)

George Edward

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Oct 23, 1878

9. AGE (In years, last birthday)

82m.

10. IF UNDER 1 YEAR, IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Blacksmith

10b. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Washington Harper

14. MOTHER'S MAIDEN NAME

Wallie Louis Harmon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mrs. Daisy Birch, same as #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Acute congestive heart failure  
Cardiovascular renal disease

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

SIGNATURE

James I Boyd

M.D.

EXAMINER'S NAME (Type)

JAMES I BOYD

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

9-1-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

RE-BURIAL

22b. DATE THEREOF

2 SEP 61

22c. NAME OF CEMETERY OR CREMATORY

RIVERVIEW CEMETERY

22d. LOCATION (City, town, or country)

RICHMOND

VIRGINIA

23. FUNERAL DIRECTOR

ROBERT J. MURPHY FUNERAL HOME

ADDRESS

3524 COLUMBIA PIKE ARLINGTON, VIRGINIA

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

SEP 5 '61

Arthur S. Hume



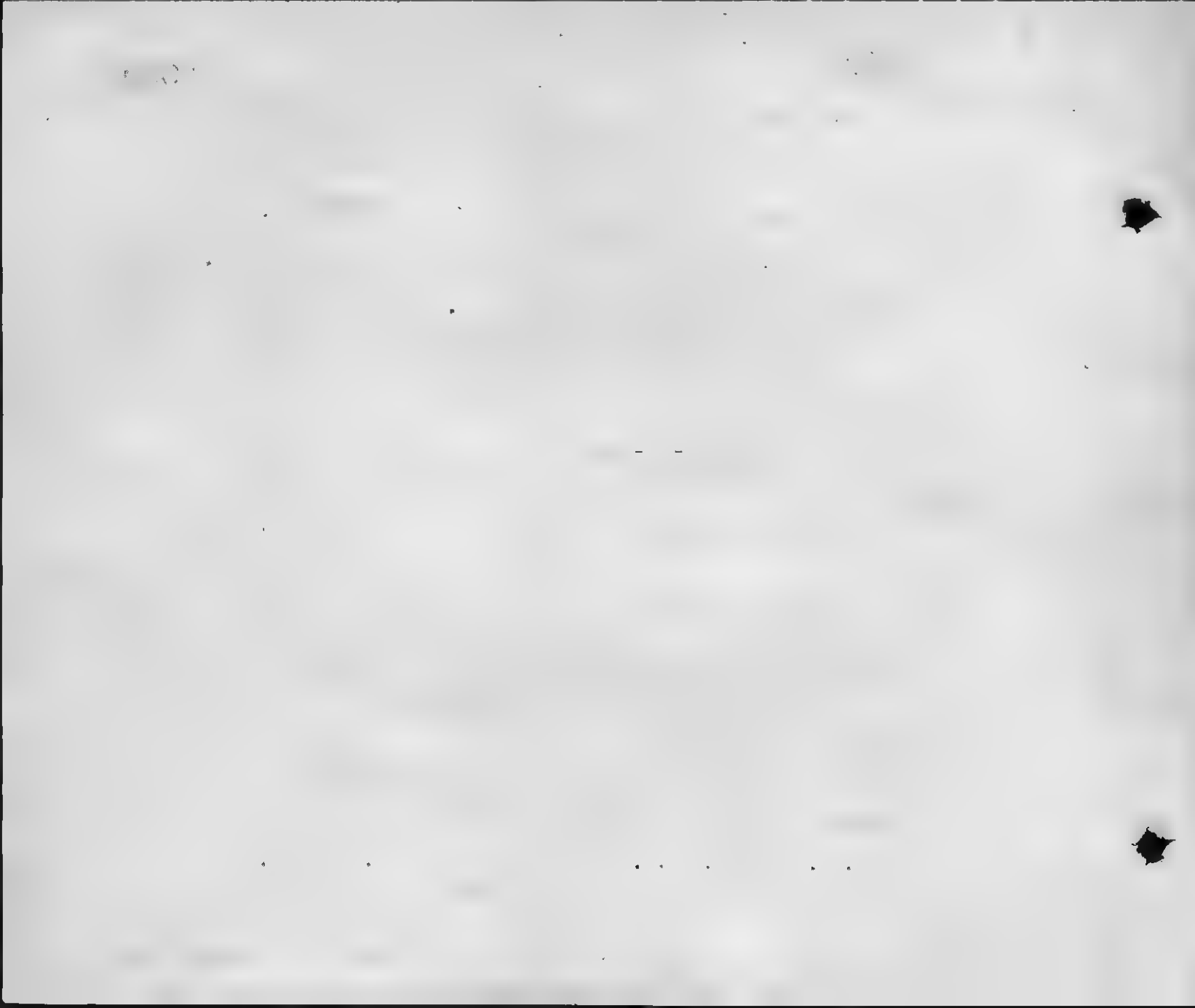
TO HOSEAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10549  
CERTIFICATE OF DEATH

10541

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b. <b>6 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE [Where deceased lived, if institutions: Residence before admission] a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b> d. STREET ADDRESS <b>2510 Virginia Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Florence V Hartley</b>		4. DATE OF DEATH <b>Sept. 30 1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>		8. DATE OF BIRTH <b>6 Oct. 1912</b>	
9. AGE (In years, last birthday) <b>48 yrs.</b>		10. IF UNDER 1 YEAR: Months <b>9</b> Days <b>29</b> Hours <b>1</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-24-3285</b>	
17. INFORMANT <b>Oscar Hartley</b>		Address <b>Landover, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute pulmonary edema</b> DUE TO (b) <b>hypertensive disease</b> DUE TO (c) <b>C.V.A.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9/29/61</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>9/18 1961</b> Hour a.m. <b>9-30</b> p.m. <b>12-30AM</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/18 1961</b> , to <b>9-30 1961</b> , that (I) (we) last saw the deceased alive on <b>9-30 1961</b> , and that death occurred <b>12,30AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>George Hageage</b>		22b. DATE SIGNED <b>9/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. G. Hageage., M.D.</b>		22d. ADDRESS <b>Mt. Rainier., Md</b>	
23. BURIAL, CREMATION, 23b. DATE THEREOF <b>Burial Oct 3-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln Cemetery</b>	
23d. LOCATION (City, town or county) <b>Colman Manor, Md</b>		23e. (State) <b>Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Basche</b>		24b. ADDRESS <b>Hyattsville, Md</b>	
25a. REC'D BY REGISTRAR <b>OCT 2 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 3-6 9/20/61 iwk

## CERTIFICATE OF DEATH

Reg. Dist. No. 10543

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE <b>Penna/</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		c. LENGTH OF STAY IN 1b <b>4 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FERRARA NURSING HOME</b>		d. STREET ADDRESS <b>33 Jeffrey Drive</b>	
3. NAME OF DECEASED (Type or print) LAST <b>HASTINGS</b> FIRST <b>EILEEN</b> MIDDLE <b>THERESA</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>16</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 Aug 1957</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHILD</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>JEREMIAH E. HASTINGS</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES AUDREY SCHULMEYER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>N/A</b>	
17. INFORMANT <b>FATHER</b>		Address <b>33 JEFFREY DR. HYATTSVILLE, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MENINGEOMYELOCELE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>HYDROCEPHALUS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SPASTIC TETRAPLEGIA</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/20</b> , 19 <b>57</b> , to <b>10/16</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>10/16</b> , 19 <b>61</b> , and that death occurred at <b>9:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7309 RIGGS RD. HYATTSVILLE, MD.</b> DATE SIGNED <b>9/16/61</b> ACTUAL SIGNATURE <b>Joseph J. McDonald</b> M.D. PHYSICIAN'S NAME (Type) <b>JOSEPH J. McDONALD</b> <b>HYATTSVILLE, MD.</b>			
22a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/18/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. J. Ruck</b>		24a. REC'D BY REGISTRAR <b>SEP 20 '61</b>	
ADDRESS <b>5305 HARFORD Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G297 10/2/61 mb

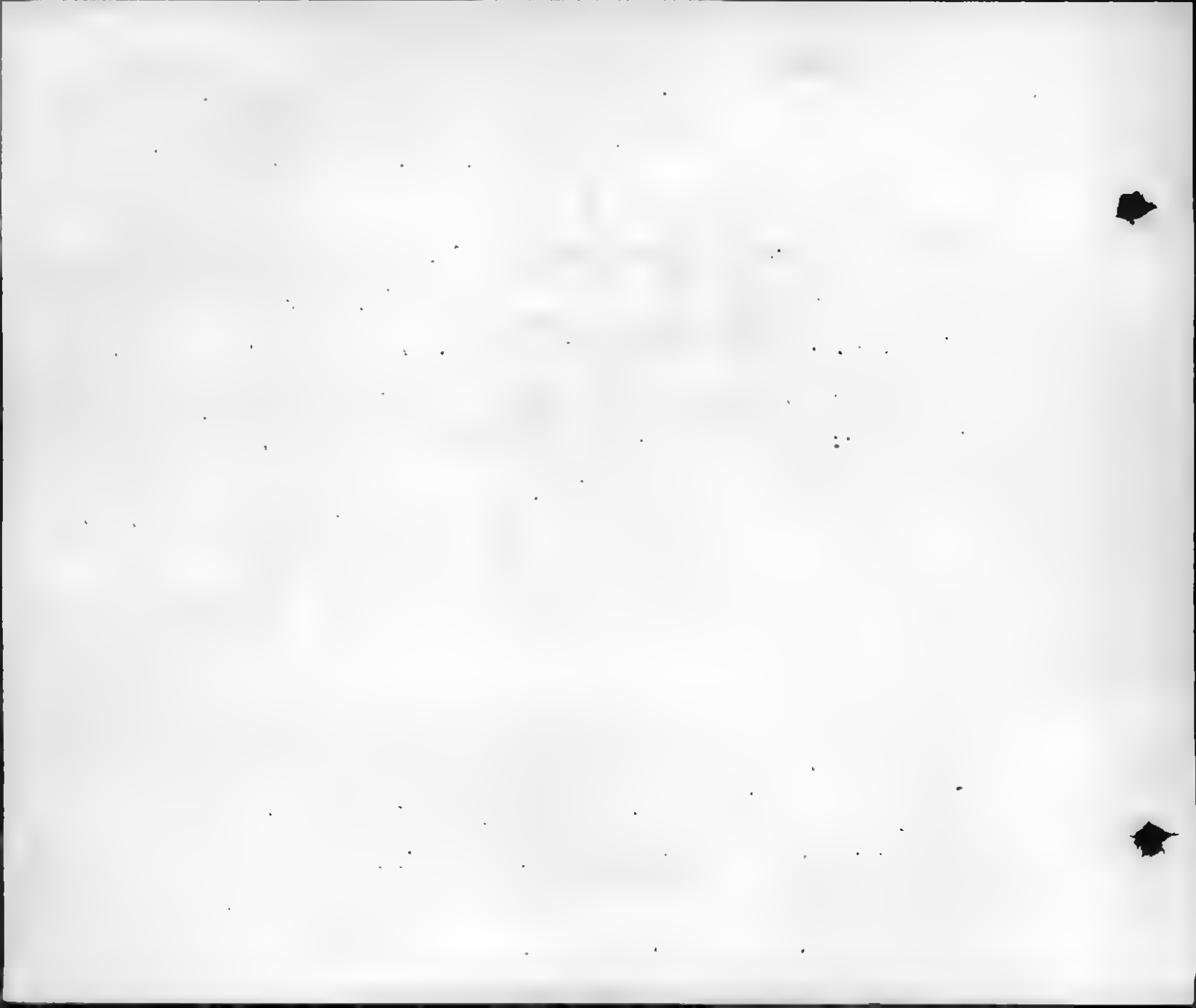
## CERTIFICATE OF DEATH

Reg. Dist. No. **10544**

**10551**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>PRINCE GEORGE MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>PR. GEO.</b> <b>4430 FORT DRIVE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b>		c. LENGTH OF STAY IN 1b <b>1 MONTH</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4430 Fort Dr</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>HOWARD FRANKLIN HAYES</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>SEPT 25 1961</b>	
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1893 AUG. 2, 1897</b>
<b>9. AGE</b> (In years last birthday) yrs. <b>68</b>		<b>10. AGE</b> (In years last birthday) yrs. <b>68</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>PRESSMAN</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>PRINTING</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>FORESTVILLE, MD</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>EDWARD THOMAS HAYES</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>BESSIE STRONG</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>YES</b>		<b>16. SOCIAL SECURITY NO.</b> <b>1909-1913 NONE</b>	
<b>17. INFORMANT</b> <b>WILHEMINA M. HAYES</b>		<b>Address</b> <b>4430 FORT DRIVE</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X APOPLEXY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE HEART DISEASE</b> (c) <b>9 MONTHS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>JAN 15, 1961</b> <b>to</b> <b>SEPT 25, 1961</b> <b>that I last saw the deceased alive on</b> <b>SEPT 25, 1961</b> <b>and that death occurred at</b> <b>11 A.M.</b> <b>from the causes and on the date stated above.</b> <b>ADDRESS (Street, city or town, state)</b> <b>DATE SIGNED</b>			
<b>ACTUAL SIGNATURE</b> <b>Vincent J. DiFrancesco</b>		<b>M.D.</b> <b>2436 L'ENFANT SQUARE S.E.</b>	
<b>PHYSICIAN'S NAME (Type)</b> <b>VINCENT J. DiFRANCESCO M.D.</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>9-28-61</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Suitland, Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Lee Funeral Home - Washington D.C.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE SEP 27 61</b>	
		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur J. Hays</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

REG. 10542

10552


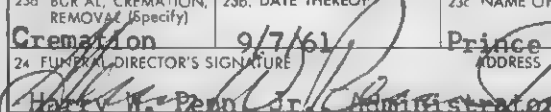
1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>Va.</u> b. COUNTY <u>Alexandria</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale</u>		c. LENGTH OF STAY IN lb <u>6 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street) address OR INSTITUTION <u>Glenn Dale Rd.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>	
f. STREET ADDRESS <u>10-West Oak St.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>Hicks</u> Last <u>Haynes</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 4, 1902</u>
9. AGE (In years lost birthday) <u>59</u> yrs		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Albermarle Co. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL E. HICKS</u>		14. MOTHER'S MAIDEN NAME <u>TEARESSA BRYANT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>227-14-4088</u>	
17. INFORMANT <u>MR Claude L Haynes</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute gastrointestinal hemorrhage</u> 151X DUE TO <u>Carcinomatosis generalized</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>Lymphosarcoma of Stomach</u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb</u> <u>1961</u> to <u>Sept 30</u> <u>1961</u> , that I last saw the deceased alive on <u>Sept 30</u> <u>1961</u> , and that death occurred at <u>2:45</u> P. M. from the causes and on the date stated above.			
ACTUAL DEATH TIME <u></u>		ADDRESS (Street, city or town, state) <u>RFD Glenn Dale Md</u> DATE SIGNED <u>9/30/61</u>	
PHYSICIAN'S NAME (Type) <u>H. James Kutz</u>		M.D. <u>R</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/4/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Alexandria Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>EVERLY-WHEATLEY FUNERAL HOME ALEXANDRIA, MD</u>		24a. REC'D BY REGISTRAR <u>OCT 5 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

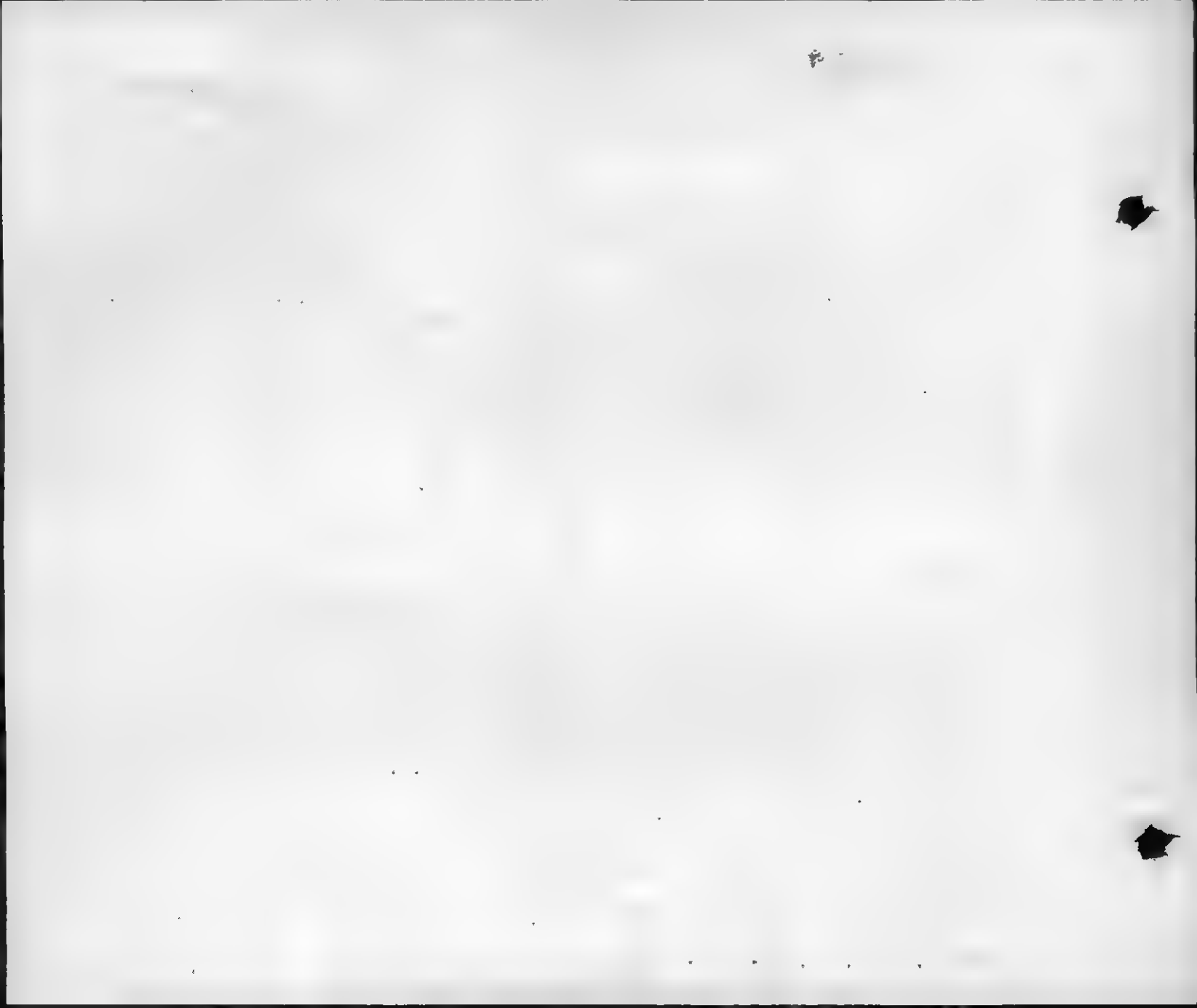


**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

10553

10545

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, give name of institution) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>66</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General</b>				e. STREET ADDRESS <b>6700 Patterson Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby Girl</b> Middle <b>Heiss</b> Last <b>Heiss</b>				4. DATE OF DEATH Month <b>September</b> Day <b>3</b> Year <b>19 61</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-2-61</b>		9. AGE (In years last birthday) <b>N.B.</b> yrs.	IF UNDER 1 YEAR Months <b>9</b> Days <b>21</b>	IF UNDER 24 HRS Hours <b>9</b> Min <b>21</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>David Clyde Heiss</b>				14. MOTHER'S MAIDEN NAME <b>Eleanor Catherine Thompson</b>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mother</b>		Address <b>as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>crematority</b> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>23 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Cheverly</b>		(County) <b>Prince George's</b>		(State) <b>Md.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>9/1</b> 19 <b>61</b> to <b>9/3</b> 19 <b>61</b> , that (I) <del>was</del> last saw the deceased alive on <b>9/3</b> 19 <b>61</b> , and that death occurred at <b>3:10 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE 		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <b>F.F. Mustey, M.D.</b>		22d. ADDRESS <b>4410 74th Ave, Landover Hills, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>9/7/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hospital</b>		23d. LOCATION (City, town, or county) <b>Cheverly, Maryland</b>		(State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE  <b>Harry H. Penn, Jr., Administrator</b>				25a. REC'D BY REGISTRAR <b>SEP 13 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>	



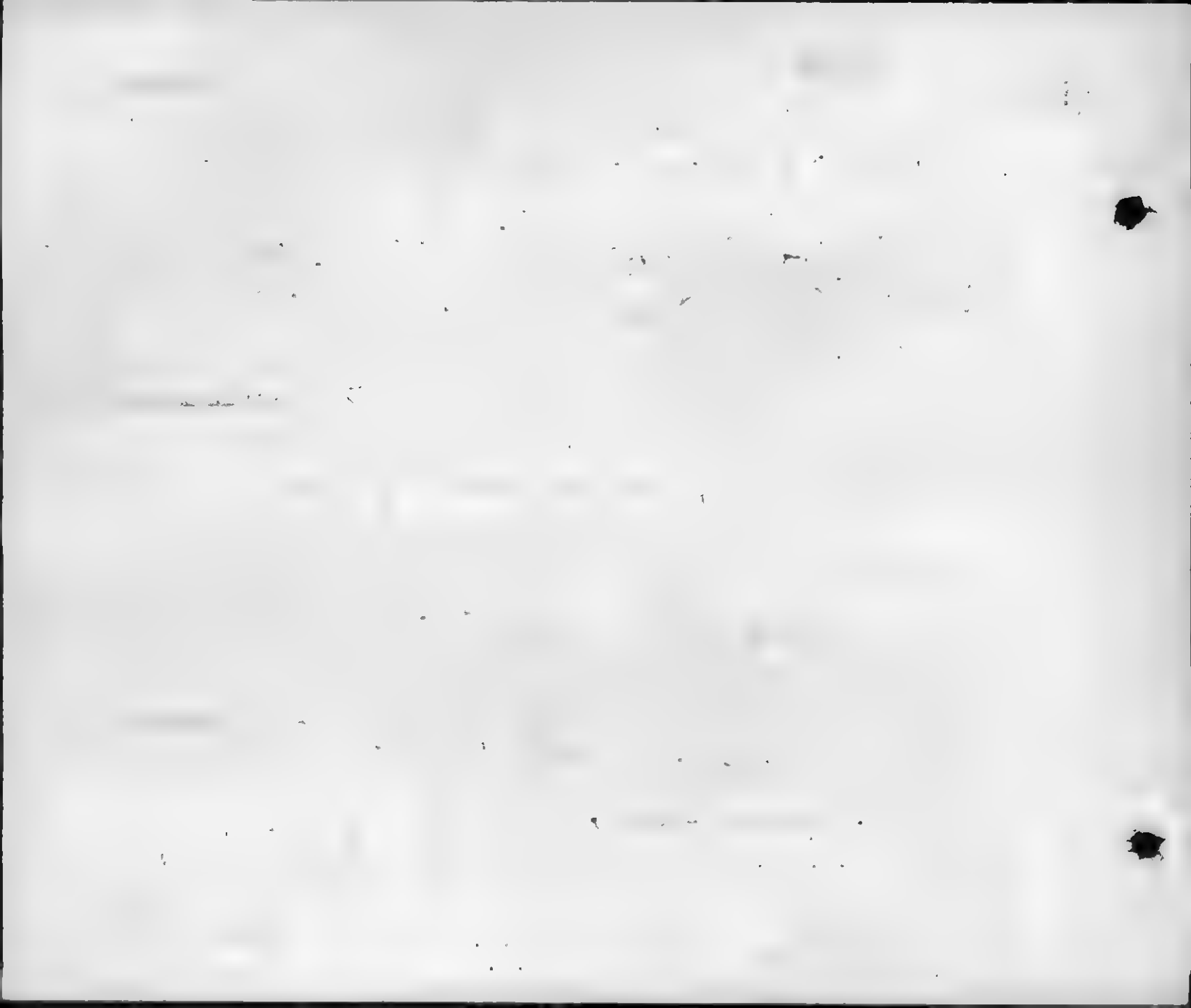
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10554

10546

1. PLACE OF DEATH o COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution-Residence for admission) o. STATE <i>Md.</i> b. COUNTY <i>P. G. 4</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Brentwood</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Brentwood</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <i>4504 41st Ave</i>		d. STREET ADDRESS <i>4504 41st Ave</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>ELLA ELEANOR HOBBS</i>		4. DATE OF DEATH Month Day Year <i>Sept 24 19 61</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 4, 1883</i>
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DC</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Matthews</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Webb</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>(if yes, give war or dates of service)</i>	
17. INFORMANT <i>MRS Gladys Johnson</i>		Address <i>4504 41st Ave</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Valvular heart disease</i> 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cephalitis, Senile</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from <i>Sept 14</i> 19 <i>61</i> to <i>Sept 24</i> 19 <i>61</i> that (I) (we) last saw the deceased alive on <i>Sept 24</i> 19 <i>61</i> , and that death occurred at <i>2:30</i> M. from the causes and on the date stated above			
22a. SIGNATURE <i>W.S. Hudson</i>		22b. DATE SIGNED <i>9/24/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>W.S. HUDSON</i>		22d. ADDRESS <i>509 R.I. Ave N.W.</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>9/27/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>LINCOLN MEM. CEMETRY</i>	23d. LOCATION (City, town, or county) (State) <i>SUITLAND MARYLAND</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert M. Lewis</i>		25a. REC'D BY REGISTRAR <i>1820 9TH ST., N.W. WASHINGTON, D.C.</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>

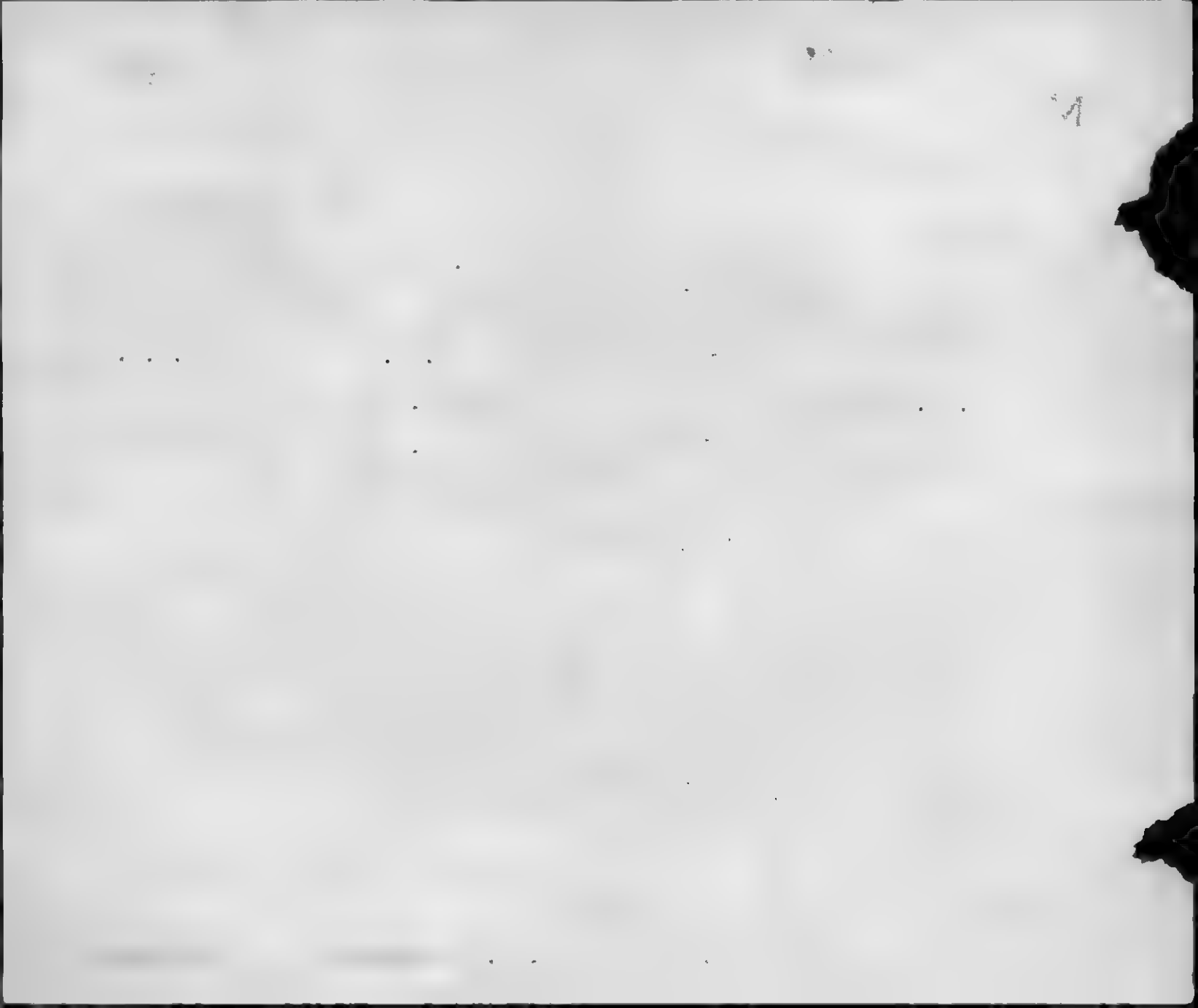
TO HOSPITAL: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be returned by the hospital or attending physician after this certificate has been signed by the attending physician and completely filled in. The funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 72 hours after death. The law requires that the death certificate be examined within 72 hours after death. The law requires that the death certificate be examined within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
10555		10547	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
a. COUNTY <b>Prince George</b>		a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b>		b. COUNTY <b>Prince George</b>	
c. LENGTH OF STAY IN b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>3600 Webster st, Brentwood</b>	
3. NAME OF (Type or print)		4. DATE OF DEATH	
First Middle Last <b>John Paul Hoffman, Sr</b>		Month Day Year <b>Sept 17 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/15/1873</b>	
9. AGE (In years, if under 1 year, if under 24 hrs) <b>88 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm. J. Hoffman</b>		14. MOTHER'S MAIDEN NAME <b>Agnes B. Sheehan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>577-14-7978</b>	
17. INFORMANT <b>Mrs Ruth C. Hoffman</b>		Address <b>3600 Webster St,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of prostate with metastasis</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastasis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>17 Sept 61</b> to <b>17 Sept 61</b> , that (I) <b>(see)</b> last saw the deceased alive on <b>17 Sept 61</b> , and that death occurred at <b>5</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>A.W. McLaughlin</b>			
22b. DATE <b>17 Sept 61</b>			
22c. PHYSICIAN'S NAME (Type) <b>A.W. McLaughlin, MD</b>			
22d. ADDRESS <b>4637 Eastern Ave</b>			
22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>9/21/61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington</b>			
23d. LOCATION (City, town or county) (State) <b>Ft Myer Va</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>			
25a. REC'D BY REGISTRAR <b>SEP 20 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



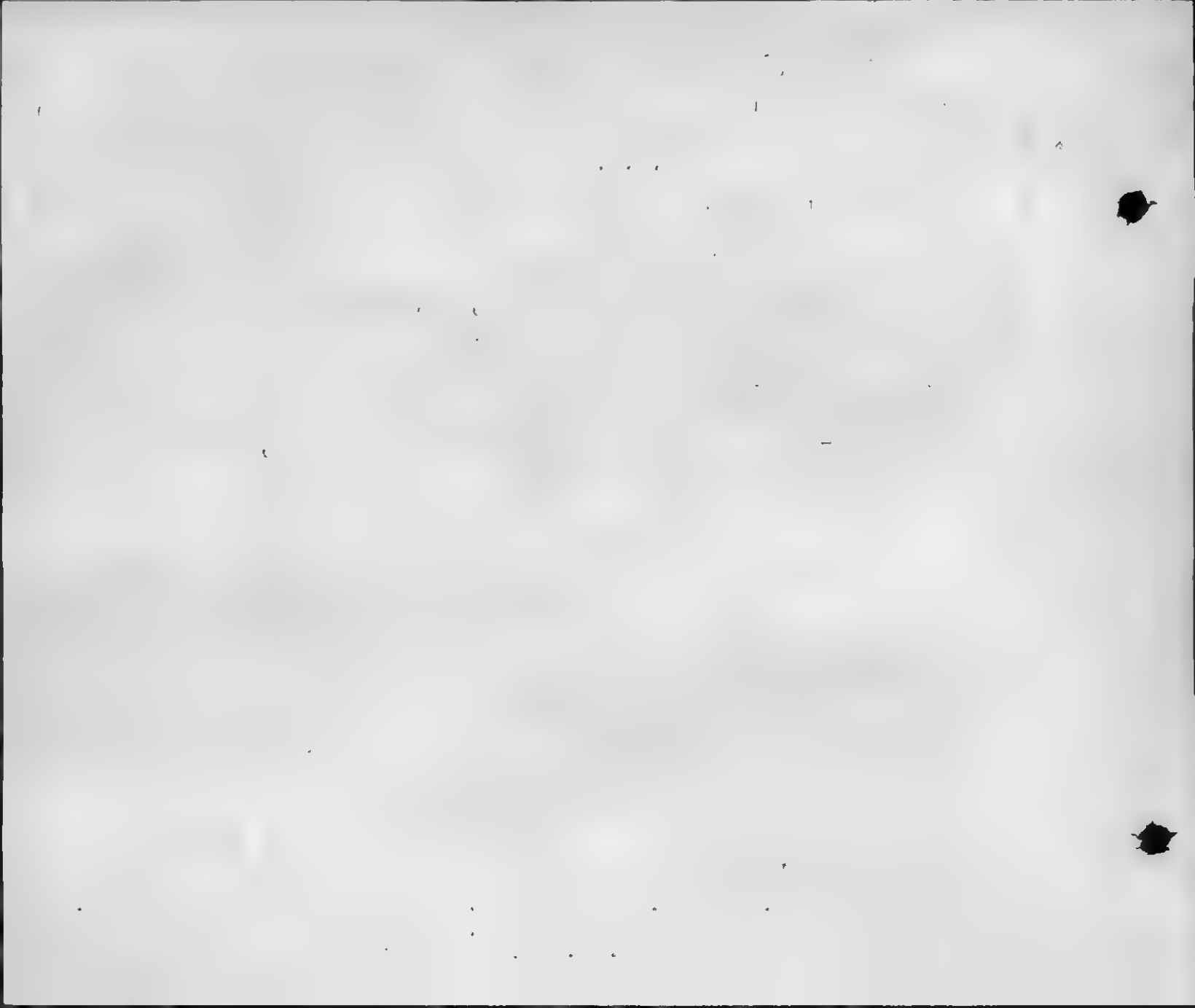
TO REPLY: MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

1  
FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10556 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Item 9 Film 4-22 4/22/61 1wk 10548									
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		e. STREET ADDRESS <b>Landover Hills</b>		f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Landover Hills</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John Howard</b>		First <b>John</b>		Middle <b>Howard</b>		Last <b>Holland Sr</b>		4. DATE OF DEATH <b>September 18 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct, 26, 1913</b>		9. AGE (In years last birthday) <b>47 48</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RCA</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Samuel Howard Holland</b>		14. MOTHER'S MAIDEN NAME <b>Mary Reamy</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1933-39</b>		17. INFORMANT <b>Estelle Bryan Holland, same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Occlusion</b> DUE TO (b) <b>Coronary artery disease</b> DUE TO (c) <b>Coronary artery disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
21. ACTUAL SIGNATURE <b>James I. Boyd</b>		21. EXAMINER'S NAME (Type) <b>James I. Boyd</b>		21. M.D. <b>James I. Boyd</b>		21. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		21. DATE SIGNED <b>9/18/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>22 Sept. 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>		22d. LOCATION (City, town, or country) <b>Bladensburg, Md.</b>		22e. REC'D BY REGISTRAR <b>SEP 20 '61</b>	
23. FUNERAL DIRECTOR <b>Lee Funeral Home</b>		23. ADDRESS <b>300-4th St. N.E.D.C.</b>		23. CITY, STATE, AND ZIP <b>Wash.</b>		24. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

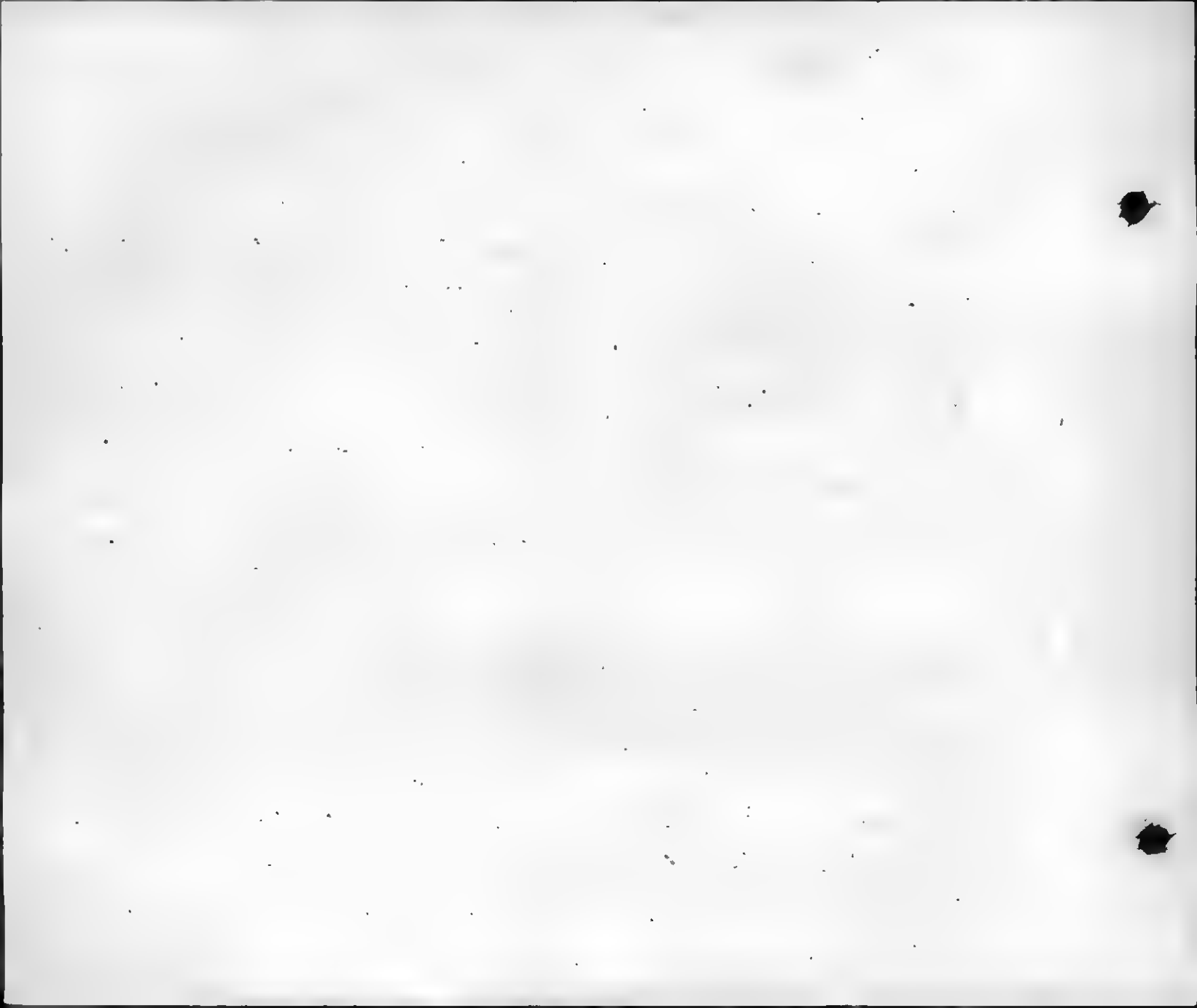
10557

## CERTIFICATE OF DEATH

Reg. Dist. No. 10549

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Switland Nursing Home</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ps. Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Scotland</u> d. STREET ADDRESS <u>4450 White Hall St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3 NAME OF DECEASED</b> (Type or print) <u>Dora</u> First <u>L</u> Middle <u>J</u> Last <u>JENKINS</u>		<b>4. DATE OF DEATH</b> <u>Sept 28</u> 19 <u>61</u>		<b>5. SEX</b> <u>Fem</u> <b>6 COLOR OR RACE</b> <u>White</u> <b>7 MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>DATE OF BIRTH</b> <u>JAN. 17. 1873</u> <b>8 AGE</b> (In years, months, days) <u>88</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS</b> Hours <u>  </u> Min <u>  </u>			
<b>10a USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Housewife</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Germany</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>US</u>		<b>13. FATHER'S NAME</b> <u>Wiet Lippold</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>MARGARET WILLIAMS</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u> <b>16 SOCIAL SECURITY NO.</b> <u>no</u> <b>INFORMANT</b> <u>R. L. Jenkins Jr.</u> <b>Address</b> <u>4216 Rd. Switland</u>			
<b>18 CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac failure</u> 44-X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular</u> DUE TO (c) <u>Renal Disease - Sickle</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 days</u> <u>unknown</u>			
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT.ON GIVEN IN PART I (c)</b> <u>none of note</u>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <u>Natural Causes</u>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		<b>20d INJURY OCCURRED</b> While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>			
<b>21. I certify</b> that I attended the deceased from <u>Jan 1</u> , 19 <u>59</u> , to <u>Sept 28</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Sept 27</u> , 19 <u>61</u> , and that death occurred at <u>7:40</u> A. M., from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <u>5440 Silver Hill Rd SE Washington 28 DC</u> <b>DATE SIGNED</b> <u>  </u>							
<b>ACTUAL SIGNATURE</b> <u>Paul C. Van Natta</u> M.D. <b>PHYSICIAN'S NAME (Type)</b> <u>PAUL C VAN NATTA</u>							
<b>22a BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b DATE THEREOF</b> <u>9-30-1961</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u> <b>22d. LOCATION</b> (City, town, or county) (State) <u>Switland, Maryland</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. W. Lee</u> <b>ADDRESS</b> <u>Wash. D. C.</u> <b>24a. REC'D BY REGISTRAR</b> <u>  </u> <b>DATE</b> <u>OCT 2 '61</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur E. Knepp</u>					

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

10550

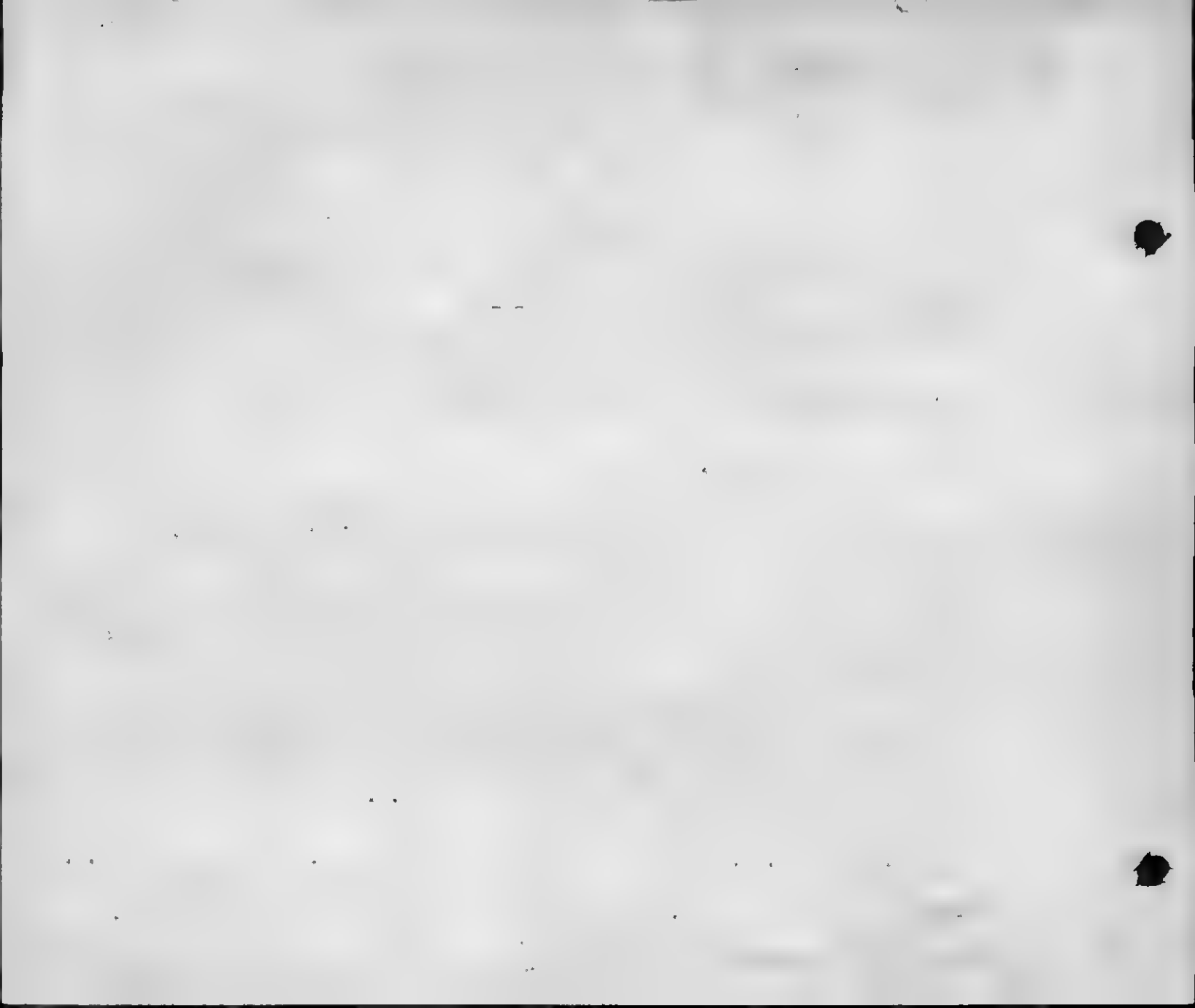
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10558

Item 7-111m G-24 10/17/61 ink

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Aquasco</b> d. STREET ADDRESS <b>Eagle Harbor, RFD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Caroline</b> 4. SEX <b>Female</b>		5. COLOR OR RACE <b>Colored</b>		6. DATE OF DEATH <b>September 25 1961</b>	
7. MARRIED <input checked="" type="checkbox"/> YES MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-6-84</b>		9. AGE (In years, F UNDER 1 YEAR, If UNDER 24 HRS., last birthday) Months Days Hours Min. <b>77 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State or foreign country)	
13. FATHER'S NAME <b>Rowell Norfolk</b>		14. MOTHER'S MAIDEN NAME <b>Cordelia Earl</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Joseph Jones--Eagle Harbor, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute pul. edema</b> DUE TO <b>Arteriosclerotic Hb. disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 20 1961</b> to <b>Sept 25 1961</b> , that (I) (we) last saw the deceased alive on <b>Sept 25 1961</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Samuel J. N. Sugar</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Samuel J. N. Sugar</b>		22d. ADDRESS <b>4637 Eastern Ave., Washington 18, D.C.</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, or other disposition <b>BURIAL</b>		23b. DATE THEREOF <b>9/30/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Edmonds Methodist Church</b>	
23d. LOCATION (City, town or county) <b>Calvert County, Md.</b>		23e. STATE <b>Md.</b>		23f. REC'D BY REGISTRAR <b>SEP 29 '61</b>	
23g. REGISTRAR'S SIGNATURE <b>John T. Stewart Jr.</b>		23h. ADDRESS <b>30 H St. N.E.</b>		23i. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No. 10551

10559

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Aquasco</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		d. STREET ADDRESS <u>Home</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE YOUNG JONES</u>		4. DATE OF DEATH Month Day Year <u>SEPT 18 19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1901</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Aquasco Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>JOSEPH H. YOUNG</u>	
14. MOTHER'S MAIDEN NAME <u>MARGARET GIBBONS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>217-36-5832</u>		17. INFORMANT <u>Arthur Jones - Aquasco Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Myocardial Failure</u> DUE TO <u>Cardio Vascular Collapse</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatous</u> DUE TO (c) <u>Carcinomatous</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 week</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 13 19 60</u> to <u>Sept 18 19 61</u> , that I last saw the deceased alive on <u>Sept 18 19 61</u> , and that death occurred at <u>7:30 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Taher M. Seron</u> M.D.		ADDRESS (Street, city or town, state) <u>Aquasco Md</u> DATE SIGNED <u>9/18/61</u>	
PATIENT'S NAME (Type) <u>VAHEH M. SERON MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-20-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST MARYS</u>	22d. LOCATION (City, town, or county) (State) <u>Aquasco, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The HUNTT Funeral Home, Waldorf, MD.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 26 '61</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Robert S. Plana</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

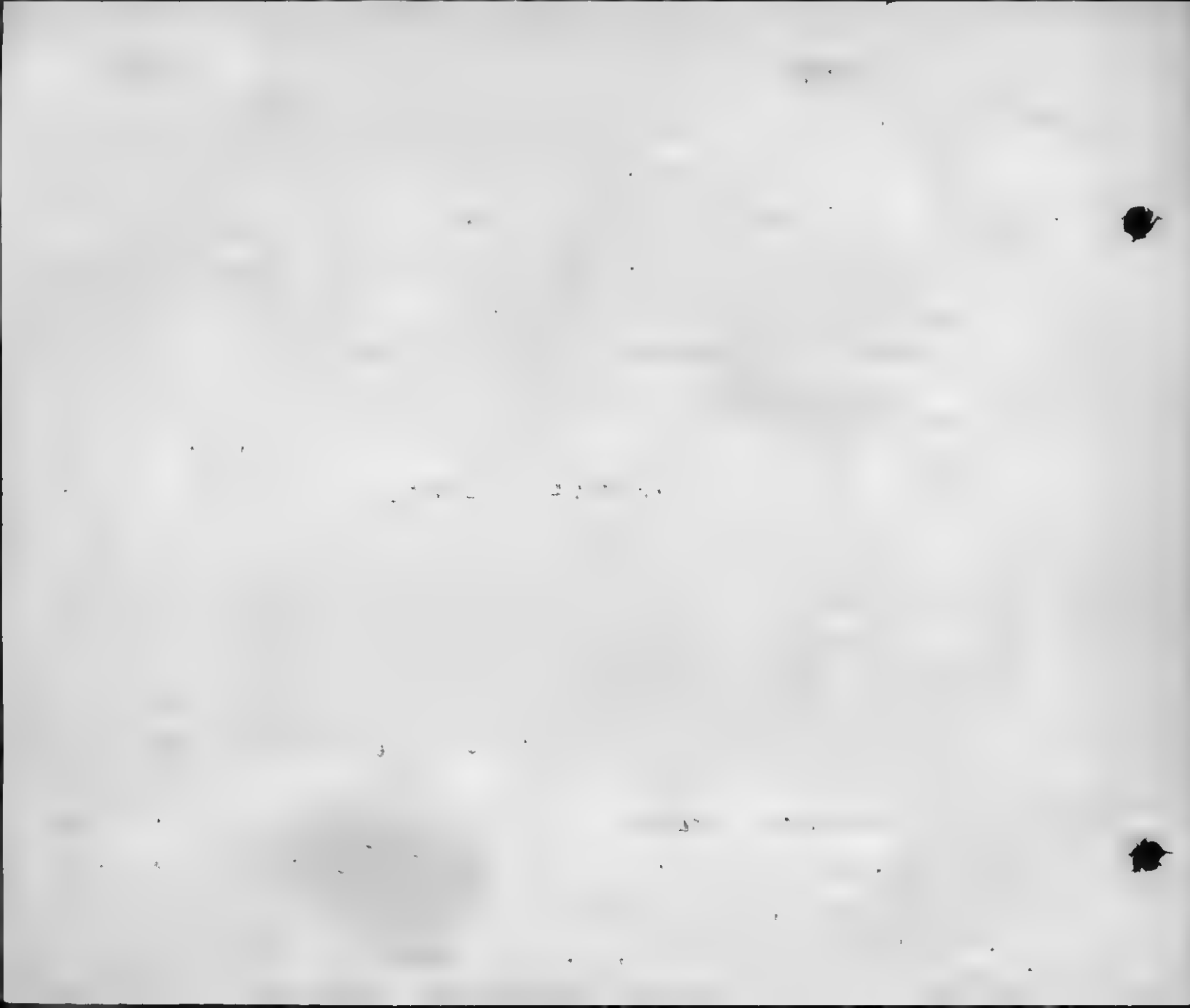
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10560

10552

<b>1. PLACE OF DEATH</b> a. COJNTY Prince George's MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b. 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Landover d. STREET ADDRESS Rt. 1			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Julia Z. Jones		<b>4. DATE OF DEATH</b> Month Day Year Sept. 15 1961		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> Female		<b>6. COLOR OR RACE</b> White		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> 1-1-14		<b>9. AGE</b> (in years) 47 yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housewife		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> own Home		<b>11. BIRTHPLACE</b> County & State or foreign country Pennsylvania			
<b>12. CITIZEN OF WHAT COUNTRY?</b> U S A		<b>13. FATHER'S NAME</b> Lawrence Zabinski		<b>14. MOTHER'S MAIDEN NAME</b> Unknown			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) no		<b>16. SOCIAL SECURITY NO.</b> none		<b>17. INFORMANT</b> Thomas C Jones			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c), stating the underlying cause last. (c)		Cerebral haem.		<b>INTERVAL BETWEEN ONSET AND DEATH</b> 300s			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a)</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19					
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from 9-5-1961, to 9-15-1961, that (I) (we) last saw the deceased alive on 9-15-1961, and that death occurred 4 P.M., from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> Leonard Hays		<b>22b. DATE SIGNED</b> 9-15-61		<b>22c. PHYSICIAN'S NAME</b> (Type) Dr. Leonard Hays			
<b>22d. ADDRESS</b> Hyattsville, Md.		<b>22e. REC'D BY REGISTRAR</b> 22f. REGISTRAR'S SIGNATURE					
<b>23a. BURIAL, CREMATION REMOVAL</b> (Specify) Burial		<b>23b. DATE THEREOF</b> Sept 19, 1961		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Ft Lincoln Cemetery			
<b>23d. LOCATION</b> (City, town or county) Colmar Manor, Md.		<b>23e. LOCATION</b> (City, town or county) (State)					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> 1. Gasch's Sons		<b>ADDRESS</b> Hyattsville, Md.					



## CERTIFICATE OF DEATH

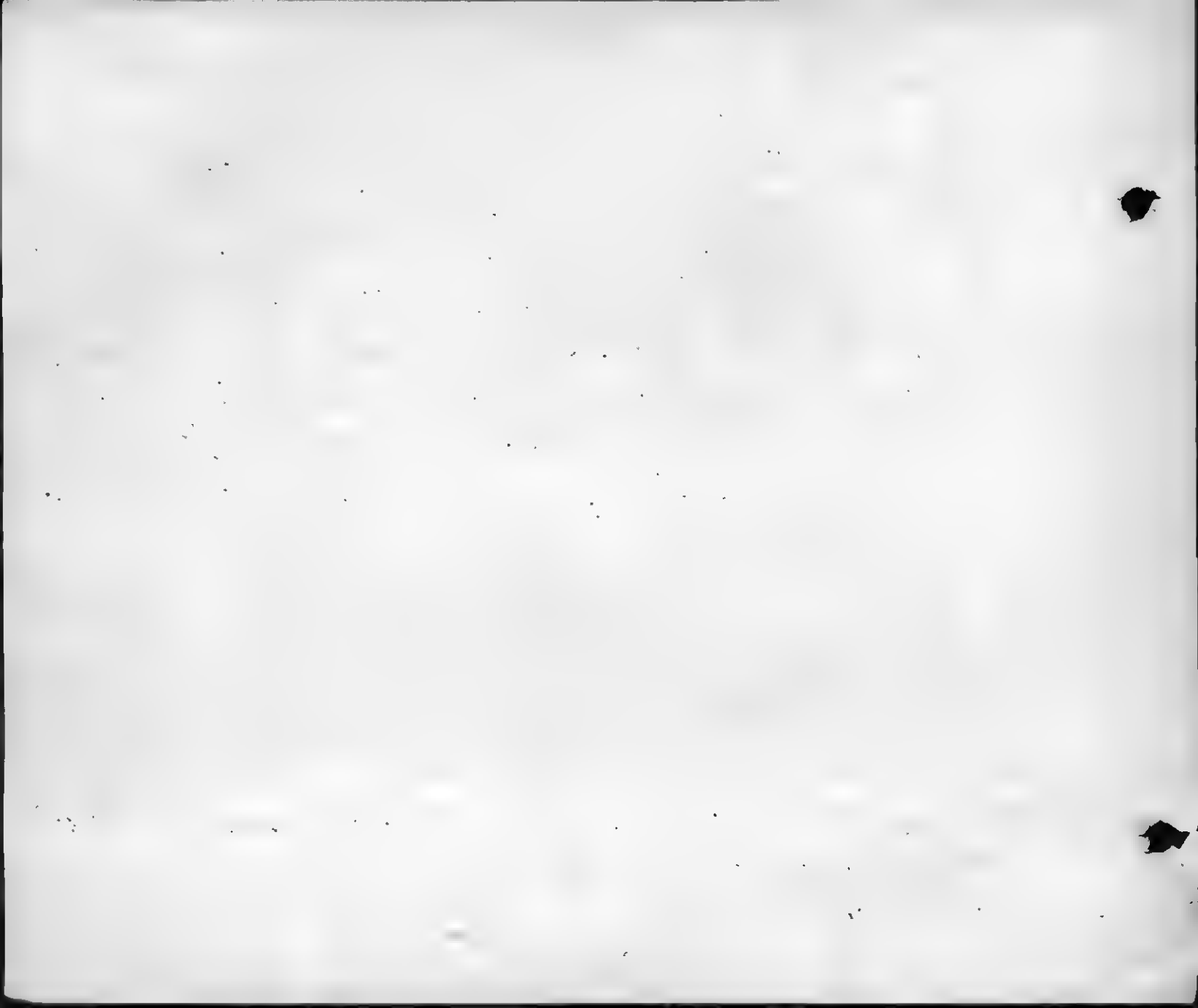
Reg. Dis. No. 10553

10561

1. PLACE OF DEATH a. COUNTY <i>Pr. George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>Pr. George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hickcrest Hgts</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>21 Seat Pleasant</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5420-21st Ave SE</i>		d. STREET ADDRESS <i>6406- Greig St</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Auguste Kewlemans</i>		4. DATE OF DEATH Month Day Year <i>Sept 2 1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 22 1896</i>
9. AGE (In years lost birthday) <i>64</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Packer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>GIANT Foods</i>	
11. BIRTHPLACE (State or foreign country) <i>Belgium</i>		12. CITIZEN OF WHAT COUNTRY? <i>Belgium</i>	
13. FATHER'S NAME <i>Alphonse Kewlemans</i>		14. MOTHER'S MAIDEN NAME <i>Clemence VAN Denabeele</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Alphonse Kewlemans</i>	
17. INFORMANT Address <i>5420-21st Ave SE Hickcrest Hgts Md</i>		18. INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hours</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute coronary thrombosis</i> 1-20-11 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9-2-</i> , 19 <i>61</i> , to <i>9-2-</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>9-2-</i> , 19 <i>61</i> , and that death occurred at <i>3P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>David S. Gordon</i>		ADDRESS (Street, city or town, state) <i>5731 23rd Parkway SE</i> DATE SIGNED <i>9-2-61</i>	
PHYSICIAN'S NAME (Type) <i>DAVID S. GORDON</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-6-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Southland Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Scrumans Bros</i>		24a. REC'D BY REGISTRAR <i>1661- Good Hope Rd SE Wash 20 DC</i> DATE <i>SEP 5 '61</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

# MARYLAND STATE DEPARTMENT OF HEALTH

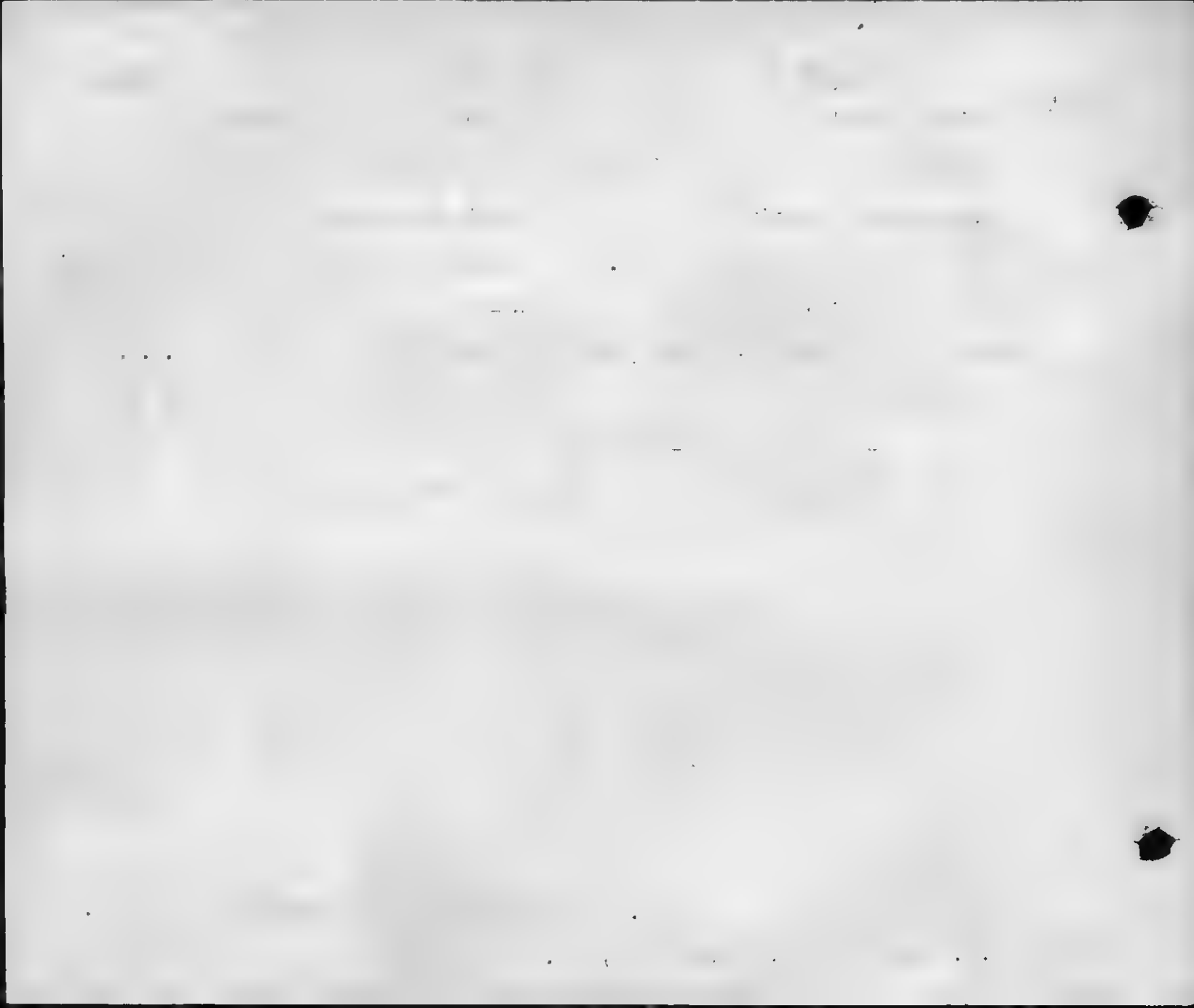
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

10562

10554

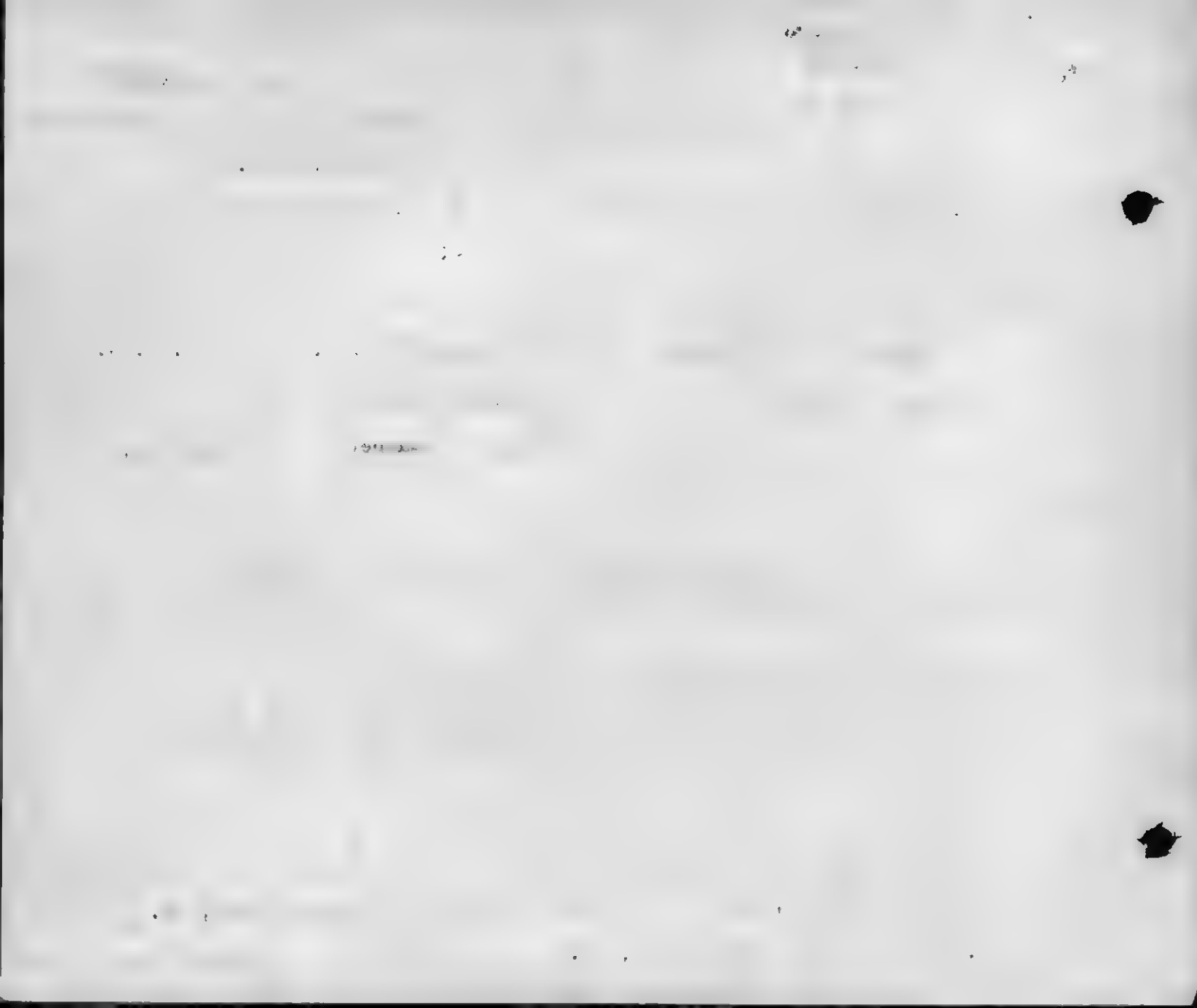
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN 1b <b>3 Weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Eugene Leland Memorial</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>6216 42nd Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Harry C. Koehler</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>9 19 1961</b>	
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>1-8-88</b>	
<b>9. AGE</b> (In years last birthday) <b>73</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Operator-Instructor Navy Yard</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>New York</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Howard Koehler</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> Yes, no, or unknown (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>578-38-6792</b>	
<b>17. INFORMANT</b> <b>Hosp records</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Cardiac arrest</b> <b>Acute myocardial infarction</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>13 days</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State) <b>Sept 6, 1961 to Sept 19, 1961</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Sept 6, 1961</b> <b>to</b> <b>Sept 19, 1961</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>Sept 19, 1961</b> , <b>and that death occurred at</b> <b>AM</b> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Ronald E. Krum</b>		<b>22b. DATE SIGNED</b> <b>Sept 19, 1961</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Krum, Ronald E.</b>		<b>22d. ADDRESS</b> <b>4404 Greenburg Rd. Riverdale, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Cremation</b>		<b>23b. DATE THEREOF</b> <b>9-22-61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Ft. Lincoln</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>Bladensburg, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W.W. Chambers Co. Riverdale, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>DATE SEP 21 '61</b> <b>Charles E. Hume</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10563											
Item 1 Film G302 1c/18/61 iwr											
10555											
1. PLACE OF DEATH a. COUNTY		Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE		Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cheverly, Md.		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		East Riverdale, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Andrews Air Force Base Hosp		d. STREET ADDRESS		6708 Hamilton Street					
3. NAME OF DECEASED (Type or print)		Raymond B. Lambert		4. DATE OF DEATH		Sep. 3, 1961					
5. SEX		M		6. COLOR OR RACE		W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 25, 1944	
9. AGE (In years last birthday)		17 yrs.		IF UNDER 1 YEAR		Months Days		IF UNDER 24 HRS.		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Student		10b. KIND OF BUSINESS OR INDUSTRY		school		11. BIRTHPLACE (County & State, or foreign country)		Washington D. C.	
13. FATHER'S NAME		Raymond M Lambert		14. MOTHER'S MAIDEN NAME		Sara Burgess		12. CITIZEN OF WHAT COUNTRY?		U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		No x		16. SOCIAL SECURITY NO.		none		17. INFORMANT		Raymond M. Lambert East Riverdale, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia -</u> DUE TO <u>Aspiration (intrapulmonary) of blood.</u> (b) <u>Multiple blunt-force injuries to head &amp;</u> DUE TO <u>upper respiratory tract hemorrhage.</u> (c) <u>Asphyxia -</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		Patient thrown out of car		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour <u>9:30</u> p.m. <u>9/3/61</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, factory, street, office building, etc.)		P. 2. Ave & Suitland Hwy.		20f. (City or town)		Pr. Georges Co.		20g. (County)		Md.	
21. I certify that (I) (this hospital) attended the deceased from <u>2:30 AM (9/3, 1961)</u> to <u>2:30 (9/3, 1961)</u> that (I) (we) last saw the deceased alive on <u>9/3/61</u> 19 <u>61</u> , and that death occurred at <u>2:30 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE		Howard N. Stewart		22b. DATE SIGNED		9/3/61		22c. PHYSICIAN'S NAME (Type)		Howard N. STEWART	
22d. ADDRESS		Andrews Air Force Base Hosp., Md.		22e. REC'D BY REGISTRAR		SEP 7 '61		22f. REGISTRAR'S SIGNATURE		Arthur S. Thomas	
23a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		23b. DATE THEREOF		Sept 6, 1961		23c. NAME OF CEMETERY OR CREMATORY		Ft Lincoln Cemetery	
23d. LOCATION (City, town or county)		Colmar Manor, Md.		23e. NAME OF CEMETERY OR CREMATORY		Ft Lincoln Cemetery		23f. LOCATION (City, town or county)		Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		F. Gasch's Sons		24b. ADDRESS		Hyattsville, Md.		24c. REC'D BY REGISTRAR		SEP 7 '61	



## CERTIFICATE OF DEATH

Reg. Dist. No.

10564

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERWYN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERWYN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8720 63RD AVE</u>				e. STREET ADDRESS <u>8720 63RD AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DELAHY LAYTON</u>				4. DATE OF DEATH Month Day Year <u>SEPT 1 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 14, 1895</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIRE FIGHTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ST. ELIZ. HOSPITAL, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>BROOK CO. NEW YORK</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN LAYTON</u>				14. MOTHER'S MAIDEN NAME <u>ROSIE GATES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-28-6131</u>		17. INFORMANT <u>DAISY M. LAYTON</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Rectum with General metastases</u> DUE TO <u>154X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>6 mo</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-23-61</u> , 19 <u>61</u> , to <u>8-29</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8-29</u> , 19 <u>61</u> , and that death occurred at <u>9:30</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>9-1-61</u>							
ACTUAL SIGNATURE <u>LW Malin</u> M.D.				PHYSICIAN'S NAME (Type) <u>LW Malin M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-5-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Riverdale, Maryland</u>				24a. REC'D BY REGISTRAR <u>SEP 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10565 CERTIFICATE OF DEATH 10557									
1. PLACE OF DEATH a. COUNTY Prince Georges			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY D. C.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)			c. LENGTH OF STAY IN 1b 2 yrs., 2 mos., & 4 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital						d. STREET ADDRESS 617 H. St., N.W.		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Glenn Dale Lee			4. DATE OF DEATH 9 14 19 61						
5. SEX Male		6. COLOR OR RACE (Chinese) white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/15/02		9. AGE (in years last birthday) 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laundry worker			10b. KIND OF BUSINESS OR INDUSTRY Owner of Laundry			11. BIRTHPLACE (County & State, or foreign country) China		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lee Him Kong			14. MOTHER'S MAIDEN NAME Chin See						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No			16. SOCIAL SECURITY NO Unknown		17. INFORMANT Decedent		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the liver, probably metastatic, primary unknown. DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause first, (c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), 19. WAS AUTOPSY PERFORMED? Pulmonary tuberculosis, far advanced active (20 years); internal hemorrhoids resected 8/14/61; addiction to heroin (historical) 19. <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7/10/1961 to 9/14/1961, that (I) (we) last saw the deceased alive on 9/14/1961, and that death occurred at P.M. from the causes and on the date stated above.									
22a. SIGNATURE Moe Weiss			22b. DATE SIGNED 9/14/61		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 9-19-61		23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cem.		23d. LOCATION (City, town or county) (State) Hyattsville Md.		
24. FUNERAL DIRECTOR'S SIGNATURE J. M. Lee & Sons			ADDRESS 300 H. St. N.E.		25a. REC'D BY REGISTRAR DATE SEP 19 61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



1  
FOR STATE  
HEALTH DEPT.

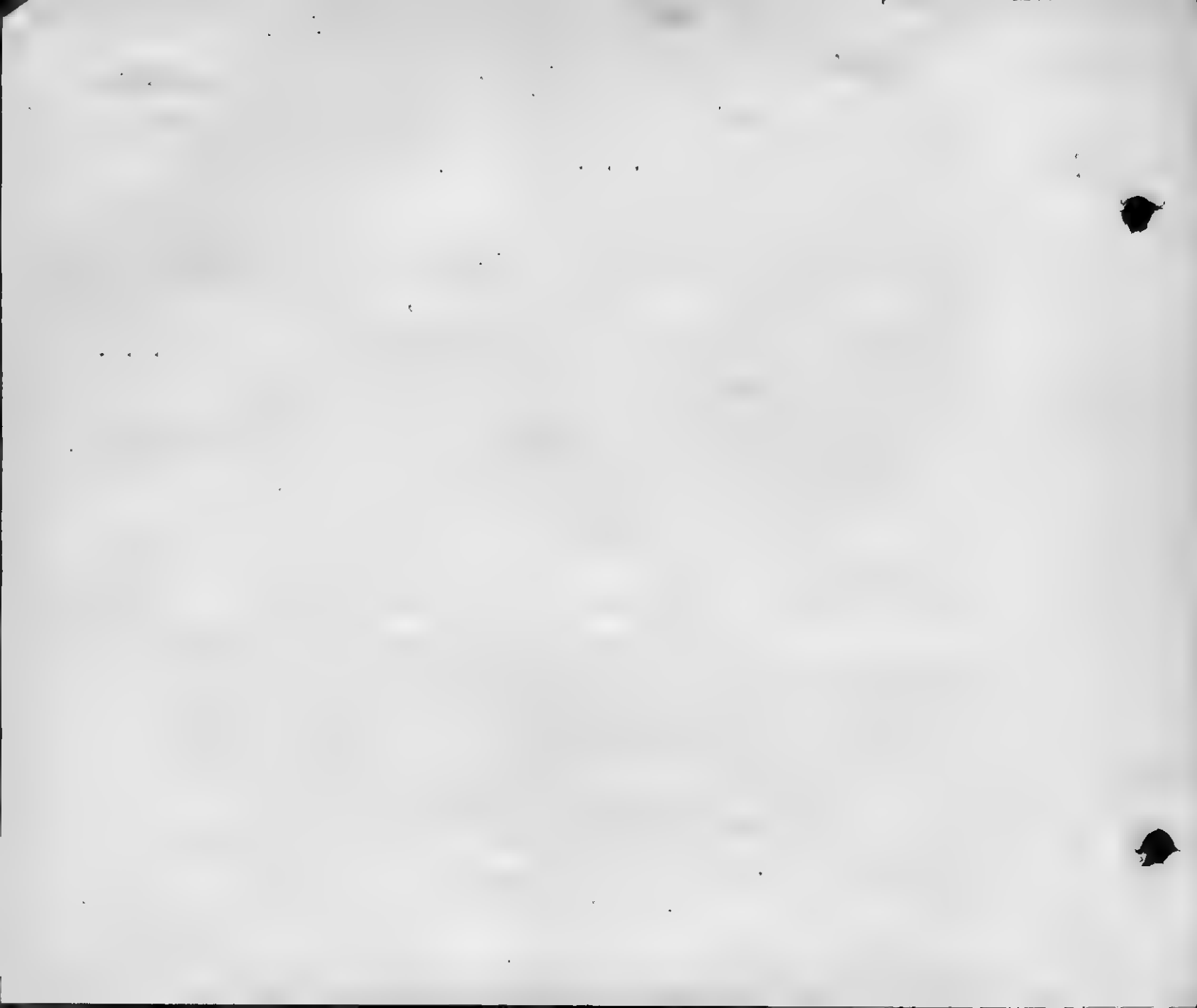
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10566 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10559

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, give name and address) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>3724 34th Street</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Raymond Little</b>		4. DATE OF DEATH Month <b>September</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 14, 1906</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Emanuel Odie Little</b>		14. MOTHER'S MAIDEN NAME <b>Harriette Parks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW 11</b>		16. SOCIAL SECURITY NO. <b>4134 40th Street</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>442 X</b> DUE TO <b>442 X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>9/20/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/23/61</b>	
22c. NAME OF CEMETERY OR OBTURANCE <b>St. John's Church</b>		22d. LOCATION (City, town, or county) (State) <b>Beltsville, Md.</b>	
23. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		24a. REC'D BY REGISTRAR <b>SEP 21 '61</b>	
ADDRESS <b>Hyattsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	



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 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it is to be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

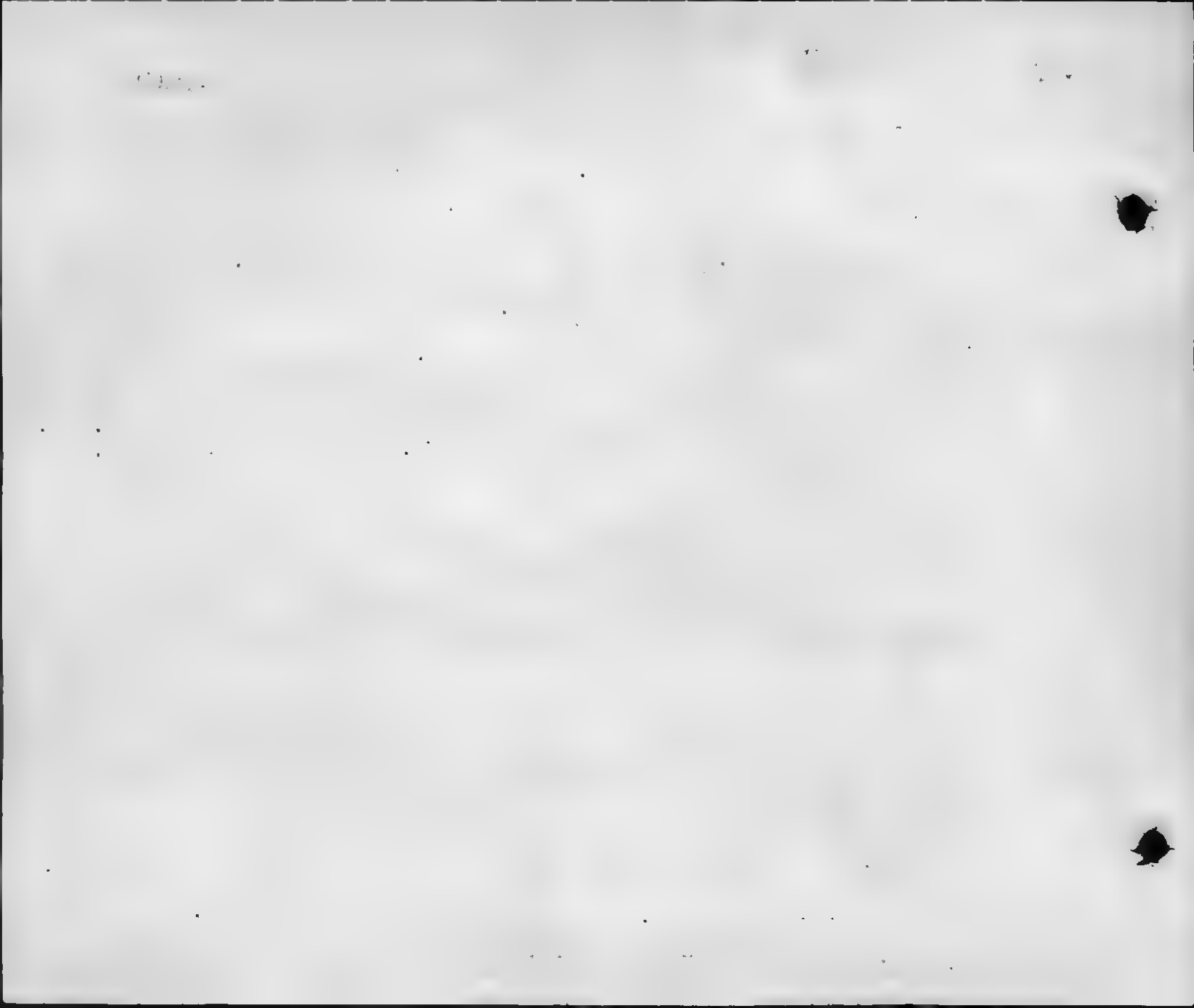
<b>10567</b>		<b>10558</b>	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg Hyattsville</u> d. STREET ADDRESS <u>4527 Buchanan Street</u>	
3. NAME OF DECEASED (Type or print) <u>Dan Eugene Lewis</u> 4. DATE OF DEATH <u>Sept. 8 1961</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 2, 1961</u> 9. AGE (In years, last birthday) <u>7</u> yrs. <u>8</u> months <u>7</u> days <u>18</u> hours <u>15</u> min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Dan Hurl Lewis</u> 14. MOTHER'S MAIDEN NAME <u>Barbara Ann Pannebaker</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Hospital Record</u> Address _____	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>76-10</u> DUE TO <u>Obtention Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> 20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____ 20c. INJURY OCCURRED Where at work <input type="checkbox"/> Not Where at work <input type="checkbox"/> 20d. PLACE OF INJURY (Home, farm, factory, street, office, etc.) _____ 20e. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>9/2</u> 19 <u>61</u> to <u>9/8</u> 19 <u>61</u> ; that (I) (we) last saw the deceased alive on <u>9/8</u> 19 <u>61</u> , and that death occurred at _____ M, from the causes and on the date stated above. 22a. SIGNATURE <u>John Perkins</u> M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Dr. W. Perkins</u> 22d. ADDRESS <u>5301 Hamilton Street, Hyattsville, Md.</u> 22b. DATE SIGNED _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9/9/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u> 23d. LOCATION (City, town or county) <u>Baldensburg, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 13 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10568											
10560											
1. PLACE OF DEATH a. COUNTY Prince George's				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville				c. LENGTH OF STAY IN 1b 5 yrs.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hospital				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Winifred S. Loftus				4. DATE OF DEATH Sept. 1, 1961				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 30, 1875		9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Post Mistress				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick O'Sullivan				14. MOTHER'S MAIDEN NAME				Address 4801 Conn. Av.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)				16. SOCIAL SECURITY NO. 1-111-111111				17. INFORMANT Address 4801 Conn. Av.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 425-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Myocardial infarct (c) Arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension				INTERVAL BETWEEN ONSET AND DEATH minutes minutes Years				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year: 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug. 1958 to Sept. 1961, that (I) (we) last saw the deceased alive on June 30, 1961, and that death occurred at 7A.M. from the causes and on the date stated above.											
22a. SIGNATURE Richard P. Delaney				22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) RICHARD P. DELANEY MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9-2-61				23c. NAME OF CEMETERY OR CREMATORY St. Anne's Cemetery			
24. FUNERAL DIRECTOR'S SIGNATURE J. Collins				25a. REC'D BY REGISTRAR DATE SEP 8 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Knap			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

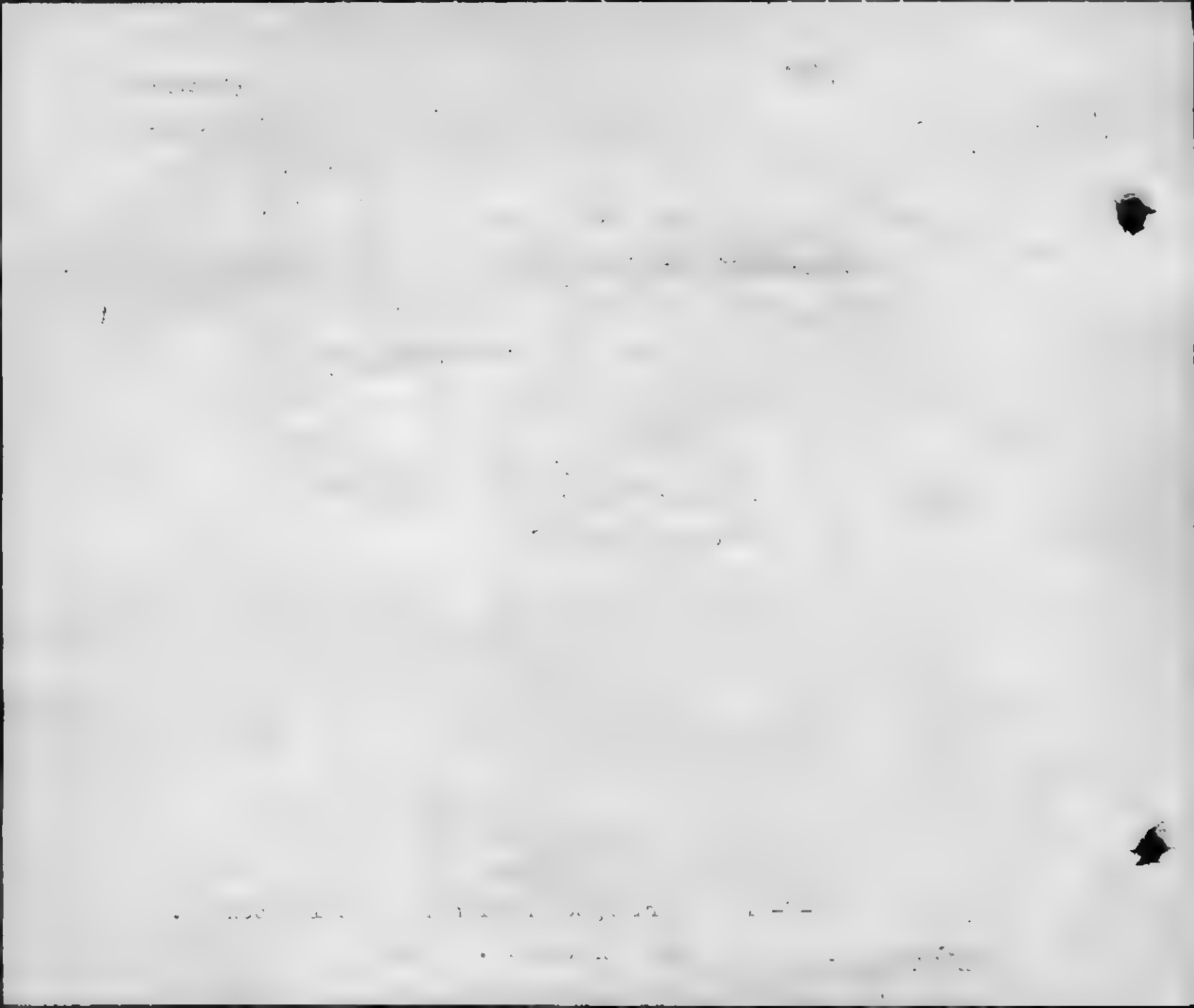
10569

10561

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Camp Springs</u> c. LENGTH OF STAY in 1b <u>21 hrs 10 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANDREWS Air Force Hosp, MD.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, in institution, or residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland Park</u> d. STREET ADDRESS <u>1205 70th Ave</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>COLETTE MADISON</u>				<b>4. DATE OF DEATH</b> Month <u>SEPT</u> Day <u>4</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Negroid</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3 SEPT. '61</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>9. AGE</b> (In years, last birthday) <u>21</u> <b>MONTHS</b> <u>10</u> <b>DAYS</b> <u>10</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Prince Georges, Md.</u>	
<b>13. FATHER'S NAME</b> <u>WILLIAM J. MADISON</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>SHIRLEY PROCTOR</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>			
<b>17. INFORMANT</b> <u>Hospital Chart</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Atelectasis lung</u> (b) <u>762.5</u> DUE TO (c) <u>PREMATURITY.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>21 hours</u>							
<b>19. WAS AN AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg, etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that</b> (this hospital) attended the deceased from <u>3 Sept.</u> 19 <u>61</u> , to <u>4 Sept.</u> 19 <u>61</u> , that (we) last saw the deceased alive on <u>4 Sept.</u> 19 <u>61</u> , and that death occurred at <u>2:19</u> p.m. from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Nicholas P. Haritos</u>				<b>22b. DATE SIGNED</b> <u>4 Sept 61</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>NICHOLAS P. HARITOS, CAPT</u>				<b>22d. ADDRESS</b> <u>USAF HOSPITAL ANDREWS, MD</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>9-7-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Arlington Va.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Butt Taylor</u>				<b>ADDRESS</b> <u>909 6th St. N.W.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>SEP 7 '61</u>	
				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. FOR STATE HEALTH DEPT.

(M)

1. PLACE OF DEATH  
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

3. NAME OF DECEASED  
(Type or print)

Angeline

Manderacchi

5. SEX

Female

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH April 13, 1917

9. AGE (In years last birthday) 44 yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machine Operator

10b. KIND OF BUSINESS OR INDUSTRY

Garment Mfg.

11. BIRTHPLACE (State or foreign country)

Norristown, Penna.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Joseph Venezia

14. MOTHER'S MAIDEN NAME

Maria Tulone

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO. UNKNOWN

Vincent Venezia

Address

Chalfont, Penna.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Hemorrhage and shock

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO  
(c) DUE TO

Crushed chest, fracture of the skull

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Head on collision with another automobile

20c. TIME OF INJURY

Hour a.m. 12:48xx

Month, Day, Year 9/8/ 19 61

20d. INJURY OCCURRED

While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Route 301

Upper Marlboro P.G. Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

James I. Boyd

M.D.

EXAMINER'S NAME (Type)

JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

Sept. 8, 1961

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

9-12-1961

22c. NAME OF CEMETERY OR CREMATORY

St. Patrick's Riverdale, Md.

22d. LOCATION (City, town or country)

Norristown, Penna.

23. FUNERAL DIRECTOR

W. W. Chambers, 5801 Cleveland Ave.

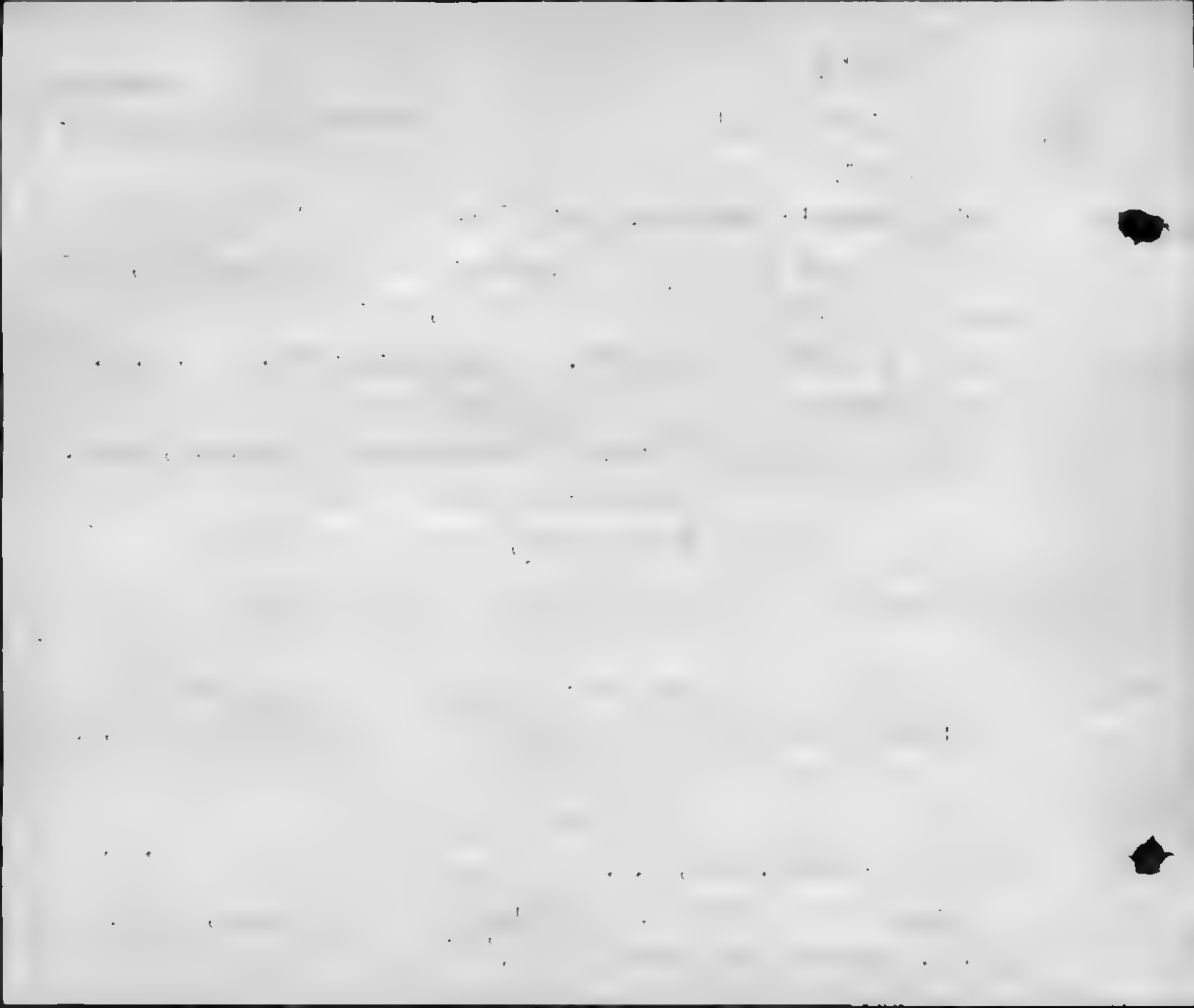
24a. REC'D BY REGISTRAR

SEP 13 '61

24b. REGISTRAR'S SIGNATURE

William S. Thomas

THIS DEPT. MEDICAL EXAMINER'S CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER'S OFFICE ALONG WITH FORM PM-3. PAGE 5 MAY BE RETAINED FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. FILE PAGES 1 AND 2 WITH THE STATE BOARD OF HEALTH, OR ITS DESIGNATED AGENT, PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT WITHIN 72 HOURS AFTER DEATH.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10571 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10563											
1. PLACE OF DEATH a. COUNTY <u>Pr George</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u> c. LENGTH OF STAY IN 1b <u>DoA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pr George General Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cedar Heights</u> d. STREET ADDRESS <u>6403 Lee Place</u>					
3. NAME OF DECEASED (Type or print) <u>George Robert</u>						4. DATE OF DEATH Month <u>9</u> Day <u>15</u> Year <u>1961</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 14, 1888</u>		9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Mahns</u>						14. MOTHER'S MAIDEN NAME <u>Adeline Queen</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Florence Baker Triangle</u> Address <u>Box 146, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO <u>Congestive heart failure</u> } DUE TO <u>Arterio Sclerotic Heart disease</u> <u>4 mo</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED		
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county) <u>9-16-61</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9-20-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smith Hill</u>		22d. LOCATION (City, town, or country) (State) <u>Quantico, Va</u>					
23. FUNERAL DIRECTOR <u>Phyllis R. Collins</u> Address <u>4339 Hunt Pl. N.E., Wash. D.C.</u>						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			
						DATE <u>SEP 20 '61</u>					

(M)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
10572  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>30 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>College PK.</u>	
3. NAME OF DECEASED (Type or print) <u>FRANCIS L MARLOW</u>		d. STREET ADDRESS <u>9026 49TH PL.</u>	
5 SEX <u>MALE</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>30</u> Year <u>1961</u>	
6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRED <input type="checkbox"/> B. DATE OF BIRTH <u>April 21, 1909</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Repair man</u>		9. AGE (in years last birthday) <u>52 yrs.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>		11. BIRTHPLACE (County, State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>George N. Marlow</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. MOTHER'S MARDEN NAME <u>Katherine Ellen Hammond</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>(If yes give number or date of service)</u>		17. INFORMANT <u>Lydia H. Marlow Same as # 2 Wife</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Aortic Stenosis</u> (a), stating the underlying cause (c) <u>Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Hereditary Cerebellar Ataxia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>2 yrs</u> <u>2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1956</u> to <u>9/30</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>9/30</u> , 19 <u>61</u> and that death occurred at <u>3:40</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman Donat Cimeau</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Norman Donat Cimeau</u>		22d. ADDRESS <u>3503 PENNYST MT PARKWAY MD</u>	
22b. DATE SIGNED <u>9/30/61</u>			
23a. BURIAL, CREMATION, or other disposition (Specify) <u>XXXXX Burial</u>		23b. DATE THEREOF <u>10/2/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor. Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Maryland</u>	
25a. REC'D BY REGISTRAR DATE <u>OCT 2 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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10573

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6309-Murkirk Rd.		d. STREET ADDRESS 6309-Murkirk Rd.	
3. NAME OF DECEASED (Type or print) BERTIE		4. DATE OF DEATH Sept. 22, 1961	
5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 6, 1883	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Domestic		9. AGE (In years last birthday) 74 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State of foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Henson Warner	
14. MOTHER'S M.A.D.E.N. NAME Gussella Johnson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Samuel Marshall - 6311 - Murkirk Rd. Beltsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A.S.C.V.R. Disease 442X (b) Gen. Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I. or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 6/1 1938 to 9/22 1961, that (I) (we) last saw the deceased alive on 9/22 1961, and that death occurred at 6:17 P.M. from the causes and on the date stated above.		22a. SIGNATURE J M Warren M.D.	
22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-26-61	
23c. NAME OF CEMETERY OR CREMATORY Queens Chapel		23d. LOCATION (City, town or county) (State) Murkirk, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		25a. REC'D BY REGISTRAR SEP 28 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline		25c. ADDRESS Rockville, Md.	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10574

10566

### 1. PLACE OF DEATH

a. COUNTY

**PRINCE GEORGES**

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

**ANDREWS AIR FORCE BASE 3 DAYS**

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

**US AIR FORCE HOSPITAL**

### 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

e. STATE

**MARYLAND**

b. COUNTY

**PRINCE GEORGES**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

**SUITLAND**

d. STREET ADDRESS

**3456 HOMER AVENUE**

o. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

### 3. NAME OF DECEASED (Type or print)

First

**DANIEL**

Middle

**WAYNE**

Last

**MARSHALL**

### 4. DATE OF DEATH

Month

**SEPTEMBER**

Day

**14**

Year

**19 61**

### 5. SEX

**MALE**

### 6. COLOR OR RACE

**CAUCASIAN**

### 7. MARRIED

☐ NEVER MARRIED ☒

### 8. DATE OF BIRTH

**12 SEPTEMBER 1961**

### 9. AGE (In years last birthday)

**3**

### 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**NONE**

### 10b. KIND OF BUSINESS OR INDUSTRY

**NONE**

### 11. BIRTHPLACE (County & State, or foreign country)

**MARYLAND**

### 12. CITIZEN OF WHAT COUNTRY?

**UNITED STATES**

### 13. FATHER'S NAME

**HAROLD GENE MARSHALL**

### 14. MOTHER'S MAIDEN NAME

**JANET LOUISE TITUS**

### 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

**NO**

### 16. SOCIAL SECURITY NO

**NONE**

### 17. INFORMANT

**FATHER**

Address

**SAME AS ITEM #2**

### 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

**RESPIRATORY INSUFFICIENCY**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

**PREMATURE BIRTH WITH IMMATURITY**

(c)

INTERVAL BETWEEN ONSET AND DEATH  
**50 HOURS**

### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

### 20c. TIME OF INJURY (Month, Day, Year)

Hour a.m.  
p.m.

Month, Day, Year  
**19**

### 20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

### 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

**20f. (City or town)**

(County)

(State)

21. I certify that (this hospital) attended the deceased from **12 September 19 61** to **14 September 19 61**, that (we) last saw the deceased alive on **14 September 19 61**, and that death occurred at **200 P** M, from the causes and on the date stated above.

### 22a. SIGNATURE

*John A. Moore*

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

### 22b. DATE SIGNED

**14 Sep 61**

### 22c. PHYSICIAN'S NAME (Type)

**JOHN A MOORE, Major USAF MC**

### 22d. ADDRESS

**USAF HOSPITAL, ANDREWS AFB, WASH 25 DC**

### 23a. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

### 23b. DATE THEREOF

**9/16/1961**

### 23c. NAME OF CEMETERY OR CREMATORY

**Washington Nat'l Cem.**

### 23d. LOCATION (City, town or county)

**Suitland Rd., Pr. Geo. Co., Md.**

### 24. FUNERAL DIRECTOR'S SIGNATURE

### ADDRESS

**W.W. Chambers Co., 517--11th St. S.E. Wash. DC**

### 25a. REC'D BY REGISTRAR

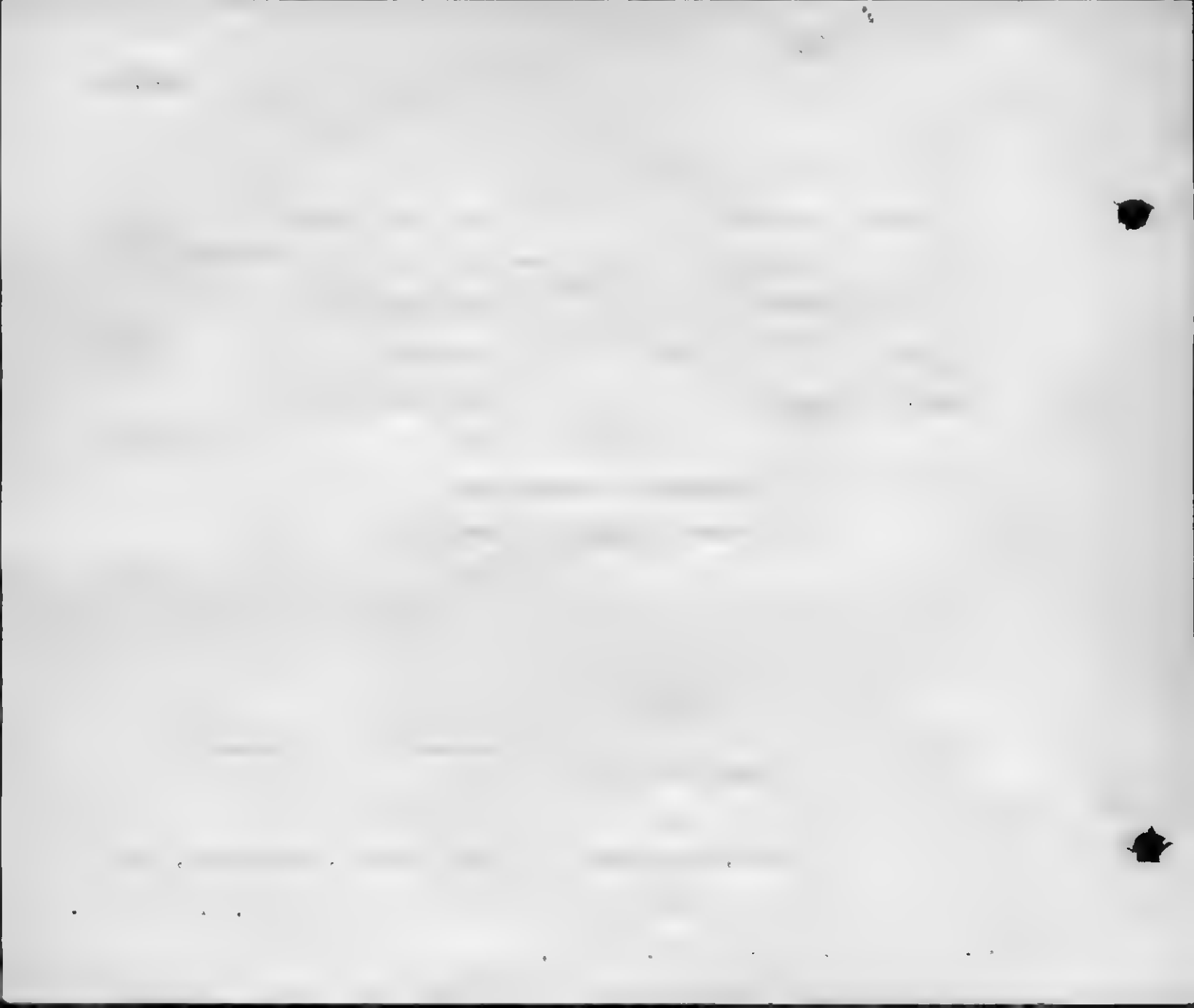
### 25b. REGISTRAR'S SIGNATURE

DATE **SEP 19 61**

*Arthur S. Kraus*

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10575

10567

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGES.</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - ADELPHI</u> c. LENGTH OF STAY IN 1b <u>5 1/2 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PAINT BRANCH NURSING HOME.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> <span style="float: right;">b. COUNTY <u>PRINCE GEORGES.</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> d. STREET ADDRESS <u>2105 Beechwood Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>ANNIE ESTELLE MASON</u>		<b>4. DATE OF DEATH</b> Month <u>9</u> Day <u>19</u> Year <u>1961</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>JUNE 3 - 1972</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>89</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>BEAUFORT, N.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA.</u>		<b>13. FATHER'S NAME</b> <u>LOUIS ALEXANDER POTTER.</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>NETTIE FISH</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>NONE</u> <b>17. INFORMANT</b> <u>PAINT BRANCH NURSING HOME RECORD</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420</u> DUE TO <u>Ac Congestive Heart Failure</u> Condition if any, which gave rise to immediate cause (b) <u>Arterio-sclerotic Heart Disease</u> (a), stating the underlying cause last. } DUE TO <u>Chc Arricular Fibrillation</u> (c)				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 yr</u> <u>1 yr</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> <u>  </u> <b>(County)</b> <u>  </u> <b>(State)</b> <u>  </u>			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>Sept 4 1961</u> to <u>Sept 19 61</u>, that (I) (we) last saw the deceased alive on <u>Sept 4 1961</u>, and that death occurred at <u>10 PM</u> from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>W.L. ETIENNE</u> <b>M.D.</b> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <u>9-19-61</u>				<b>22c. PHYSICIAN'S NAME</b> (Type) <u>W.L. ETIENNE</u> <b>22d. ADDRESS</b> <u>College St, Wash.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>9/22/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>FORT LINCOLN CEMETERY</u> <b>23d. LOCATION</b> (City, town or county) <u>BIADENSBURG MD</u> <b>(State)</b> <u>MD</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>DEAL FUNERAL HOME</u> <b>ADDRESS</b> <u>4812 GA AVE NW WASHINGTON, DC.</u> <b>25a. REC'D BY REGISTRAR</b> <u>SEP 21 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Krome</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

10576

10568

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u> <u>Bill Nursing for Children</u>		d. STREET ADDRESS <u>3713 - Alabama Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Kathleen Mastrosito</u>		4. DATE OF DEATH Month Day Year <u>Sept 13 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-15-1961</u>
9. AGE (In years last birthday) yrs Months Days Hours Min <u>2 28</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James Michael Mastrosito</u>		14. MOTHER'S MAIDEN NAME <u>Adelle Minette Sullivan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>James Michael Mastrosito</u>		Address <u>Same as</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>microcephaly (Cerebral agenesis)</u> 753 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>multiple congenital defects</u> DUE TO (c) <u>birth on</u> INTERVAL BETWEEN ONSET AND DEATH <u>birth on</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/4</u> , 19 <u>61</u> , to <u>9/13</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>9/13</u> , 19 <u>61</u> , and that death occurred at <u>3:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.		ADDRESS (Street, city or town, state) <u>College Park</u>	
PHYSICIAN'S NAME (Type) <u>T. A. Christensen</u>		DATE SIGNED <u>9/13/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-15-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Mattingly</u>		24a. REC'D BY REGISTRAR <u>SEP 18 '61</u>	
ADDRESS <u>131-11th St. S.E.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10577

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10569

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>—</b> b. COUNTY <b>DISTRICT OF COLUMBIA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLENN DALE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GLENN DALE HOSPITAL</b>		e. STREET ADDRESS <b>607-6th St. S.W.</b>	
3. NAME OF DECEASED (Type or print) <b>VIOLET MAY MAXWELL</b>		4. DATE OF DEATH Month <b>9</b> Day <b>3</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/16/22</b>
9. AGE (In years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>17</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>HINCHIE FREEMAN</b>		14. MOTHER'S MAIDEN NAME <b>LAURA BOHANAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-12-6862</b>	
17. INFORMANT <b>DECEASED</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) <b>PULMONARY TUBERCULOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 YRS, 3 MO.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>HE</b> (this hospital) attended the deceased from <b>1/4</b> , 1957 to <b>9/3</b> , 1961, that <b>WE</b> last saw the deceased alive on <b>9/3</b> , 1961, and that death occurred at <b>10:15</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>MOE WEISS</b>		22b. DATE SIGNED <b>9/3/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>MOE WEISS M.D.</b>		22d. ADDRESS <b>GLENN DALE HOSPITAL, GLENN DALE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>9-7-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Colman Manor Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Darcha Sons Hyattsville, Md</b>		25a. REC'D BY REGISTRAR <b>#577</b>	
25b. REGISTRAR'S SIGNATURE <b>SEP 8 '61</b>		25c. DATE <b>SEP 8 '61</b>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

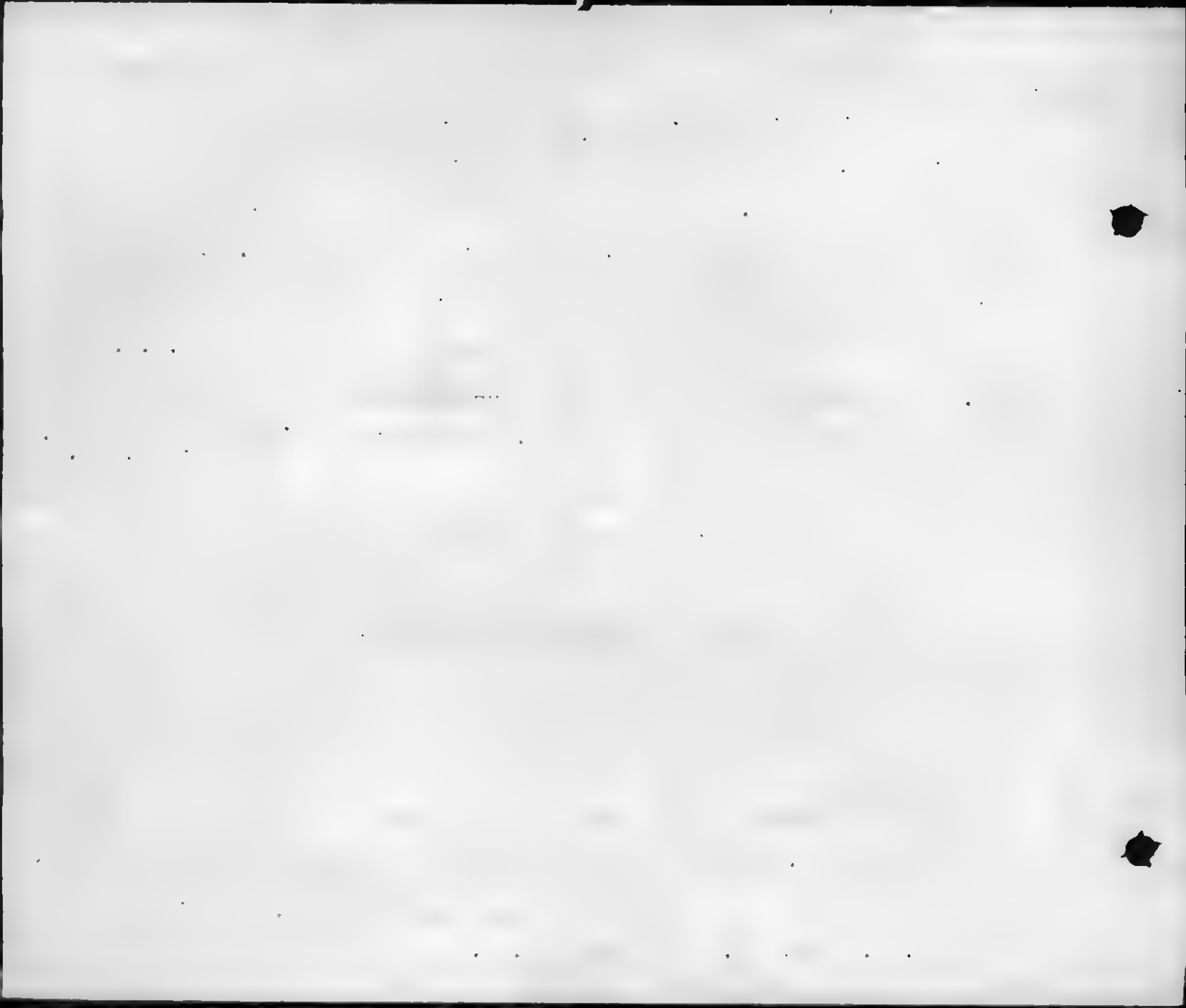
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10578

10570

1. PLACE OF DEATH a. COUNTY <b>Prince Georges Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Maryland</b>		c. LENGTH OF STAY IN 1b <b>unknown</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>5316 Annapolis Rd.</b>		d. STREET ADDRESS <b>5316 Annapolis Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Rosa</b> Middle <b>Lee</b> Last <b>Mays</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/10/1869</b>
9. AGE (In years lost birthday) yrs. <b>92</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Augusta, Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm. Thomas Armstrong</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Heath</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Mrs. Willie Lee King</b>		Address <b>5316 Annapolis Rd. Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> Conditions if any, which gave rise to immediate cause (c), stating the underlying cause lost DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4-5 DAYS</b> <b>UNKNOWN.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8/14</b> 19 <b>61</b> , to <b>9/5</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9/2</b> 19 <b>61</b> , and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>C. James Duke</b>		22b. ADDRESS <b>6607 RIVERDALE RD, RIVERDALE, MD.</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. JAMES DUKE</b>		22d. DATE SIGNED <b>9/5/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>9/6/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>West View Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Augusta, Georgia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. Washington, D. C.</b>		25. REC'D BY REGISTRAR <b>SEP 7 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			



1  
FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the Deputy Medical Examiner. Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
10579 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10579			
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>	
c. LENGTH OF STAY in 1b <u>1 mo</u>		d. STREET ADDRESS <u>4705 Longfellow St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Selane Memorial Hosp</u>			
3. NAME OF <u>Mamie</u> (Type or print) First Middle		4. DATE <u>Sept 6 1961</u> Month Day Year	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 7, 1895</u> Month Day Year	
9. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (in years, last birthday) <u>86</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Distict of Columbia U.S.A.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William A. Rutherford</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Gertrude Krocke, same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 704.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of right hip</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Interval between onset and death</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>Injury occurred in living room of home</u>	
20c. TIME OF INJURY Month, Day, Year <u>8/4 1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Riverdale P. D., Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/8/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		22d. LOCATION (City, town, or country) <u>Bladensburg, Md.</u> (State)	
23. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>		24a. REC'D BY REG. STRAR <u>SEP 8 '61</u>	
ADDRESS <u>Hyattsville, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10580

10572

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>			c. LENGTH OF STAY IN 1b <b>43 YRS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(1) SAME</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>614 MONTGOMERY ST</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>HARLEY</b> Last <b>MERSON</b>				4. DATE OF DEATH Month <b>SEPT</b> Day <b>23</b> Year <b>1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 22, 1908</b>		9. AGE (in years last birthday) <b>53 yrs.</b>	10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction PLASTERER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>LEMUEL MERSON</b>				14. MOTHER'S MAIDEN NAME <b>LOLA MERSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>(I) YES</b>		16. SOCIAL SECURITY NO. <b>213-16-262</b>		17. INFORMANT <b>RALPH BAKER 612 MONTGOMERY ST</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL MALACIA</b> <b>422</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b> <b>YRS.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from _____ 1957 to <b>PRESENT</b> 19____, the <b>(11)</b> (we) last saw the deceased alive on <b>SEPT 20 1961</b> , and that death occurred at <b>5A</b> M., from the causes and on the date stated above.							
22a. SIGNATURE <b>John R. Buell</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>9/25/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN R. BUELL</b>				22d. ADDRESS _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/25/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Long Hill Cemetery Laurel Md</b>		23d. LOCATION (City, town, or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <b>De Witt Canadian, Laurel Md</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 26 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William L. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10581

Reg. No. 10573

1. PLACE OF DEATH a. COUNTY <u>Prince Georges Hospital</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanverly Md</u>	c. LENGTH OF STAY IN 1b <u>DOA.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	d. STREET ADDRESS <u>Route #301</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KE N E T H</u> First Middle Last		4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-17-1942</u>
9. AGE (In years last birthday) <u>19</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Leonard Moore</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Belle Jackson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>John F. Moore</u> Address <u>Upper Marlboro</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and Shock</u> DUE TO (b) <u>Fracture of Skull and</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Large laceration K Occipital area</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Automobile Collision</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Collision Highway 301</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9:25</u> a.m. <u>9-16-1961</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road</u>		20f. (City or town) (County) (State) <u>Highway 301 Prince Georges Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Paul C. Van Natta</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>PAUL C. VAN NATA</u> asst		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
22e. FUNERAL DIRECTOR'S SIGNATURE		22f. REGISTRAR'S SIGNATURE	
22g. ADDRESS		22h. DATE	
22i. REC'D BY REGISTRAR		22j. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70582

Item 2 Film G-90 9/20/61 1wk

Reg. Dist. No. 10374

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Hospital</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	
		d. STREET ADDRESS <u>Rt. 301, 1</u>	
3. NAME OF DECEASED (Type or print) <u>Louis</u> First <u>L</u> Middle <u>MOORE</u> Last		4. DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-38</u>
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lunchroom</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Leonard Moore</u>		14. MOTHER'S MAIDEN NAME <u>Anna Belle Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>213 38 3328</u>	
17. INFORMANT <u>John F. Moore</u>		Address <u>Upper Marlboro Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and Shock</u> DUE TO <u>111X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of Skull and Crushed Chest</u> DUE TO <u>Sudden</u> (c) <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Collision Highway 301</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> a. m. <u>9/16</u> 1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 301</u>	20f. (City or town) <u>Pr Georges</u> (County) <u>Tud</u> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Paul C Van Natta</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>PAUL C VAN NATA</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		ASST. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-21-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Bethel Church</u>
22d. LOCATION (City, town, or county) <u>T. B.</u>		(State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle R. Collins</u>		ADDRESS <u>4339 Hunt Pl. N.E.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knease</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10583

Item 2 Film G294 9/11/61 mh

10575

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHILHAM</u> <u>BALTO.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHILHAM</u> <u>BALTO.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL MANOR</u>		d. STREET ADDRESS <u>2017 East 32nd St.</u>	
3. NAME OF DECEASED (Type or print) <u>MARY REGINA MORIARTY</u>		4. DATE OF DEATH <u>SEPT. 4, 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 9, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CONFECTIONER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>CUMBERLAND, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES E. MORIARTY</u>		14. MOTHER'S MAIDEN NAME <u>ANN ALBAUGH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>CATHERINE MORIARTY - BALT., MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>721.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac decompensation</u> (c) <u>Aortic stenosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Years</u> <u>Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (of 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 31, 1961</u> , to <u>Sept 4, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 3, 1961</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard P. Delaney</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Richard P. Delaney</u>		22d. ADDRESS <u>WHEATON, MD.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-7-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE</u>	23d. LOCATION (City, town or county) (State) <u>WASH., D.C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>JAMES T. RYAN, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 7 '61</u>	
ADDRESS <u>317 Pa. Ave. S.E.</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Puma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 10584 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10576

FOR STATE HEALTH DEPT.

### 1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb

9 hrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

### 2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Landover Hills

d. STREET ADDRESS

6916 Annapolis Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

### 3. NAME OF DECEASED (Type or print)

First

Middle

Last

Levi

Murray

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

January 6, 1889

9. AGE (In years last birthday)

72 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Physician

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Govt

11. BIRTHPLACE (State or foreign country)

Missouri

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Jamison Murray

14. MOTHER'S MAIDEN NAME

Sarah Elizabeth Dunlap

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

WW I

16. SOCIAL SECURITY NO.

216-40-0219

17. INFORMANT

Mrs Billie Mae Owens, same as # 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

INTESTINAL HEMORRHAGE

DUE TO

SEVERE hemorrhagic enterocolitis

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Aortic Insufficiency; Hypertrophy of heart

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☒. Inquiry ☒. and in my opinion death resulted from. Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

9/18/61

ACTUAL SIGNATURE

James I. Boyd

EXAMINER'S NAME (Type)

James I. Boyd

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

9-20-61

22c. NAME OF CEMETERY OR CREMATORY

ADDRESS

23. FUNERAL DIRECTOR

W W CHAMBERS CO

22b. DATE THEREOF

9-20-61

22c. NAME OF CEMETERY OR CREMATORY

ADDRESS

23. FUNERAL DIRECTOR

W W CHAMBERS CO

22b. DATE THEREOF

9-20-61

22c. NAME OF CEMETERY OR CREMATORY

ADDRESS

23. FUNERAL DIRECTOR

W W CHAMBERS CO

22b. DATE THEREOF

9-20-61

22c. NAME OF CEMETERY OR CREMATORY

ADDRESS

23. FUNERAL DIRECTOR

W W CHAMBERS CO

22b. DATE THEREOF

9-20-61

22c. NAME OF CEMETERY OR CREMATORY

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23. FUNERAL DIRECTOR

W W CHAMBERS CO

22b. DATE THEREOF

9-20-61

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23. FUNERAL DIRECTOR

W W CHAMBERS CO

22b. DATE THEREOF

9-20-61

22c. NAME OF CEMETERY OR CREMATORY

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23. FUNERAL DIRECTOR

W W CHAMBERS CO

22b. DATE THEREOF

9-20-61

22c. NAME OF CEMETERY OR CREMATORY

ADDRESS

23. FUNERAL DIRECTOR

W W CHAMBERS CO

22b. DATE THEREOF

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22c. NAME OF CEMETERY OR CREMATORY

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W W CHAMBERS CO

22b. DATE THEREOF

9-20-61

22c. NAME OF CEMETERY OR CREMATORY

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22b. DATE THEREOF

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9-20-61

22c. NAME OF CEMETERY OR CREMATORY

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22b. DATE THEREOF

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22c. NAME OF CEMETERY OR CREMATORY

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22c. NAME OF CEMETERY OR CREMATORY

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22b. DATE THEREOF

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22c. NAME OF CEMETERY OR CREMATORY

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23. FUNERAL DIRECTOR

W W CHAMBERS CO

22b. DATE THEREOF

9-20-61

22c. NAME OF CEMETERY OR CREMATORY

ADDRESS

23. FUNERAL DIRECTOR

W W CHAMBERS CO

22b. DATE THEREOF

9-20-61

22c. NAME OF CEMETERY OR CREMATORY

ADDRESS

23. FUNERAL DIRECTOR

W W CHAMBERS CO

22b. DATE THEREOF

9-20-61

22c. NAME OF CEMETERY OR CREMATORY

ADDRESS

23. FUNERAL DIRECTOR

W W CHAMBERS CO

22b. DATE THEREOF

9-20-61

22c. NAME OF CEMETERY OR CREMATORY

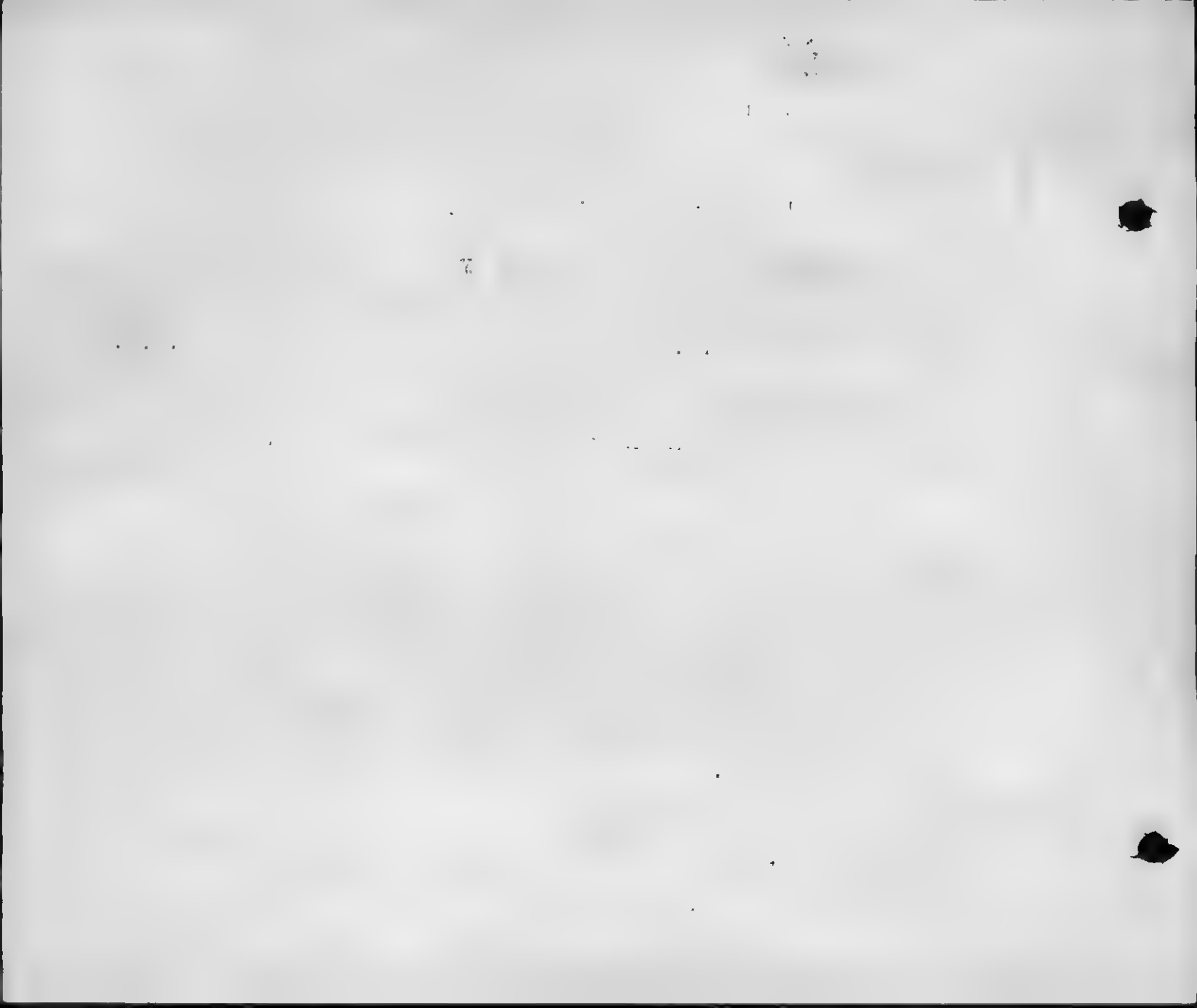
ADDRESS

23. FUNERAL DIRECTOR

W W CHAMBERS CO

22b. DATE THEREOF

9-20-61



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

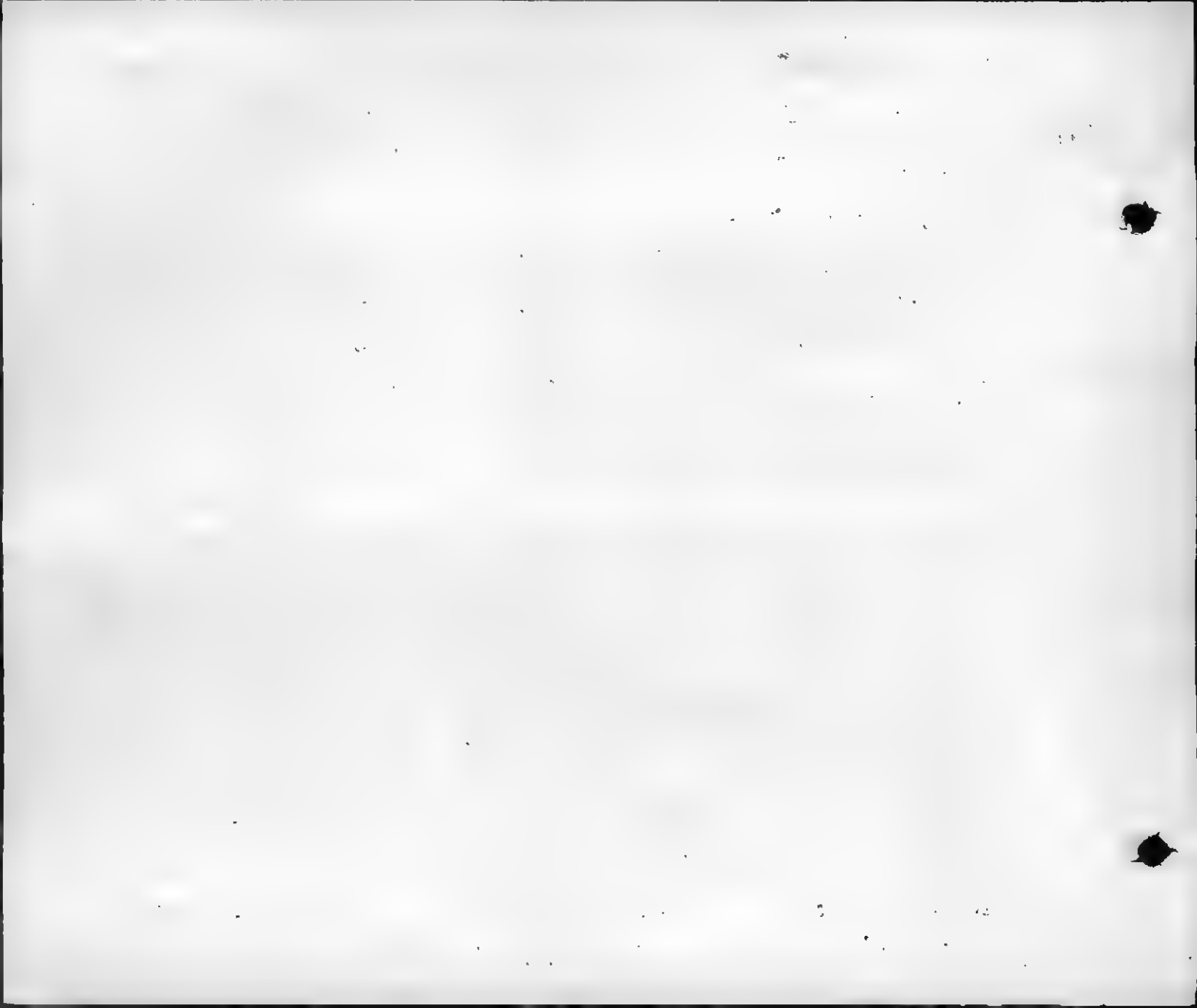
Reg. Dist. No. 10577

10585

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Hgts</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Landover</u>	
c. LENGTH OF STAY IN 1b <u>9 mo.</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>904-64-ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>VIRGIE Delydia Myles</u>		4. DATE OF DEATH Month Day Year <u>Sept. 19 1961</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May-28-1882</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Patrick Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Delydia Bell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Daniel E. Myles</u>	
17. INFORMANT Address <u>6360 Brook Rd. SE</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROSIS - GEN'L.</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>3-4</u> , 19 <u>61</u> to <u>9-19</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>9-19</u> , 19 <u>61</u> , and that death occurred at <u>1:25 PM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>H. B. Beldon</u> M.D. <u>42423-14 UNIT - PL. ME</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>H. C. Beldon</u> <u>Wash - 19 - DC</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>9/23/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>	
22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 21 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		24c. FUNERAL DIRECTOR'S SIGNATURE <u>30 H Street, N.E. Wash; D.C.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10585  
CERTIFICATE OF DEATH

Reg. Dist. No. 10378

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution—Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Capitol Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 621-51st Ave.		1 d. STREET ADDRESS 1621-51st Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN W. WHITE NAIRN		4. DATE OF DEATH Sept 5 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1893
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY DC Govt.	11. BIRTHPLACE (State or foreign country) Wash DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Geo. W. Nairn		14. MOTHER'S MAIDEN NAME Mary J. White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) Yes 1918-1919		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs. J. Nairn - 621-51st Ave		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Coronary 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart Disease DUE TO (c) 2 years INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 26 1959, to Sept 5 1961, that I last saw the deceased alive on Sept 3 1961, and that death occurred at 7:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William Brainin M.D.		ADDRESS (Street, city or town, state) 6124 Central Ave 9/5/61	
PHYSICIAN'S NAME (Type) WM BRAININ		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/61	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
SEP 7 '61		Charles S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 of 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

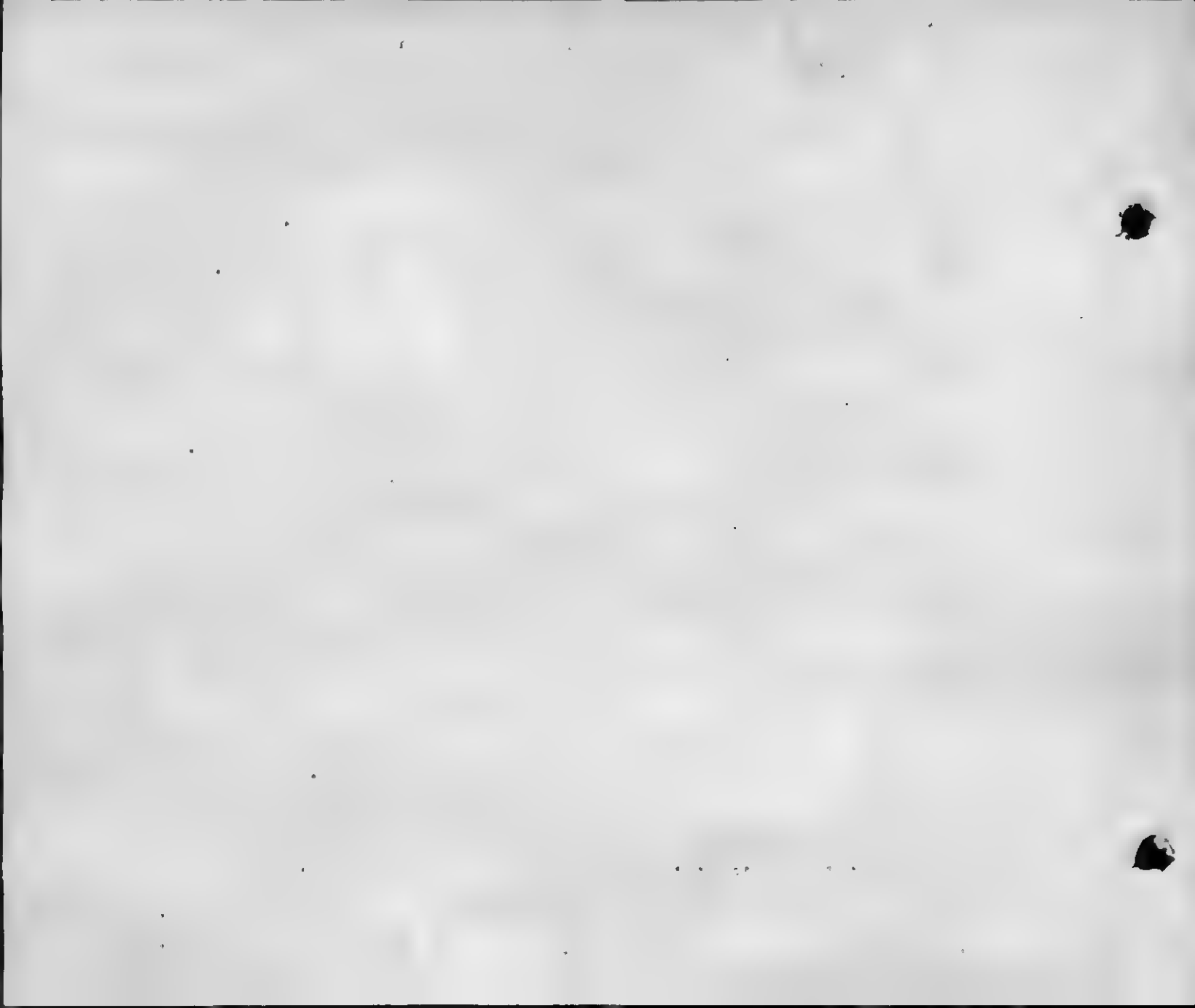


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10587 CERTIFICATE OF DEATH 10579

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN <u>16 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>5601 36th Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Frances A</u> 15. SEX <u>Female</u> 16. COLOR OR RACE <u>White</u> 17. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 18. DATE OF BIRTH <u>19 March 1909</u> 19. AGE (In years, if under 1 year; if under 24 hrs., last birthday) <u>52</u> yrs. <u>27</u> months <u>19</u> days <u>61</u> hours <u>1</u> min.		4. DATE OF DEATH <u>Sept. 27 19 61</u> 5. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Unk.</u> 14. MOTHER'S MAIDEN NAME <u>Inez Trail</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>Peter T Noon</u> 17. INFORMANT <u>Hyattsville Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Perforation of Diverticulum of ascending Colon</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>11:30 P.M.</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hyattsville, Md.</u> 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. A. Deitz</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. A. Deitz, M.D.</u>		22b. DATE SIGNED <u>11, 30 P.M.</u> 22d. ADDRESS <u>Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Sept 30, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Colmar Manor Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 2 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knease</u>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10588 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10580											
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clontown</u> c. LENGTH OF STAY IN 1b <u>11 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6840 Temple Hill Road</u>						2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clontown</u> d. STREET ADDRESS <u>6840 Temple Hill Rd</u>					
3. NAME OF DECEASED (Type or print) <u>Roger</u>			6. COLOR OR RACE <u>White</u>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>April 5, 1897</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>5</u> Year <u>1961</u>		
5. SEX <u>Male</u>			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>State Roads</u>			9. AGE (In years, if under 1 year, if under 24 hrs. last birthday) <u>64</u> yrs. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		
13. FATHER'S NAME <u>Charles H. Gursler</u>						14. MOTHER'S MAIDEN NAME <u>Anne B. Gursler</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>212-18-347</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 4 <u>2</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cardiovascular renal disease</u> (c) <u>Cardiovascular renal disease</u>						11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>Interval between ONSET AND DEATH</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASS STANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
Address (Street, city, town, or county) <u>9-5-61</u>											
DATE SIGNED <u>9-5-61</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
22b. DATE THEREOF <u>Sept 7-61</u>											
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>											
22d. LOCATION (City, town, or country) (State) <u>Burtonsville, Md</u>											
23. FUNERAL DIRECTOR <u>Simmons Bros</u>											
ADDRESS <u>1461-gd Hope Rd S E</u>											
24a. REC'D BY REGISTRAR <u>SEP 7 '61</u>											
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>											

Wash DC



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10589 Item 3 Film G297 10/2/61 10581  
M  
X  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Prin George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Suitland Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tuxedo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Walle Lane</i>		d. STREET ADDRESS <i>5500 Tuxedo Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Mattie</i> Middle <i>G.</i> Last <i>Owens</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>4</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 14, 1885</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Jacob Wattle</i>		14. MOTHER'S MAIDEN NAME <i>Mattie Lowman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO <i>—</i>	
17. INFORMANT <i>Virginia Gibbs - Kentland Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma of breast</i> <i>170X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 20, 1961</i> to <i>Sept 4, 1961</i> , that (I) (we) last saw the deceased alive on <i>Sept 4, 1961</i> , and that death occurred at <i>8 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Paul A. Devore</i> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>PAUL A. DEVORE</i>		22d. ADDRESS <i>3501 Hamilton St. - Hyattsville, Md</i>	
22b. DATE SIGNED			
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/7/61</i>	
23c. NAME OF CEMETERY OR CREMATORIUM <i>Ceder Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Suitland Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Maryland</i>	
25a. REC'D BY REGISTRAR <i>SEP 13 61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

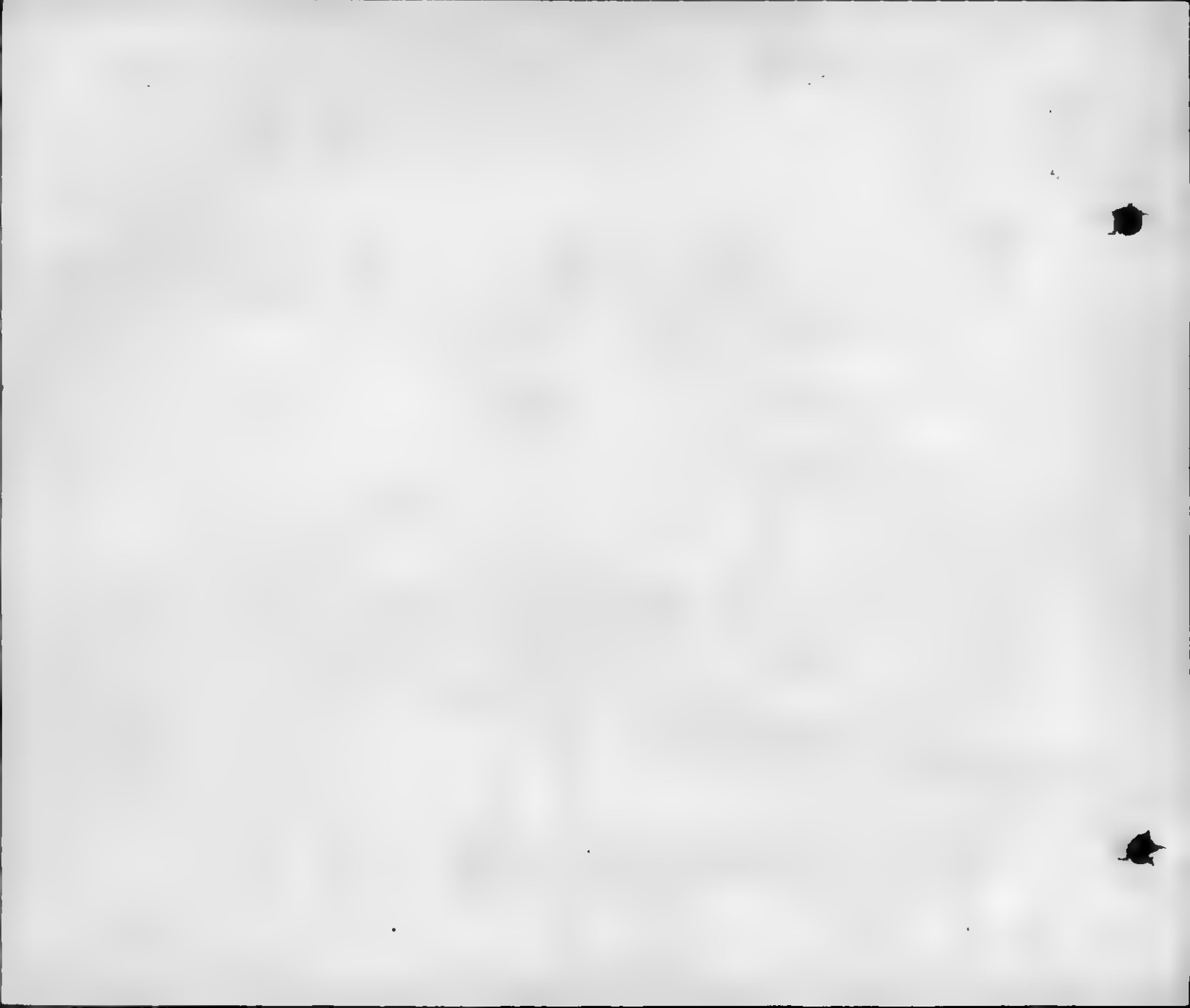
10590

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before institution) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Friendly</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8320 Old Fort Rd SE</u>		d. STREET ADDRESS <u>8320 Old Fort Rd SE</u>	
3. NAME OF DECEASED (Type or print) <u>Mary A Palmer</u>		4. DATE OF DEATH <u>Sept. 14 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1892</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Rosalie Jackson, 8320 Old Fort Rd SE</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>Hypertensive Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Decompensation</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> <u>10 years</u> <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-1-56</u> , 19 <u>56</u> , to <u>9-14-61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>9/13/61</u> , 19 <u>61</u> , and that death occurred at <u>12</u> p. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Anna Coyne Todd</u> M.D.		ADDRESS (Street, city or town, state) <u>7519 Broadview Rd S.E.</u>	
PHYSICIAN'S NAME (Type) <u>Anna A Coyne Todd</u>		DATE SIGNED <u>9/14/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-16-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NAT. HARMONY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGES COUNTY, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Pinner Co.</u>		24a. REC'D BY REGISTRAR <u>SEP 18 '61</u>	
ADDRESS <u>3015-12th St. N.E. Washington, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



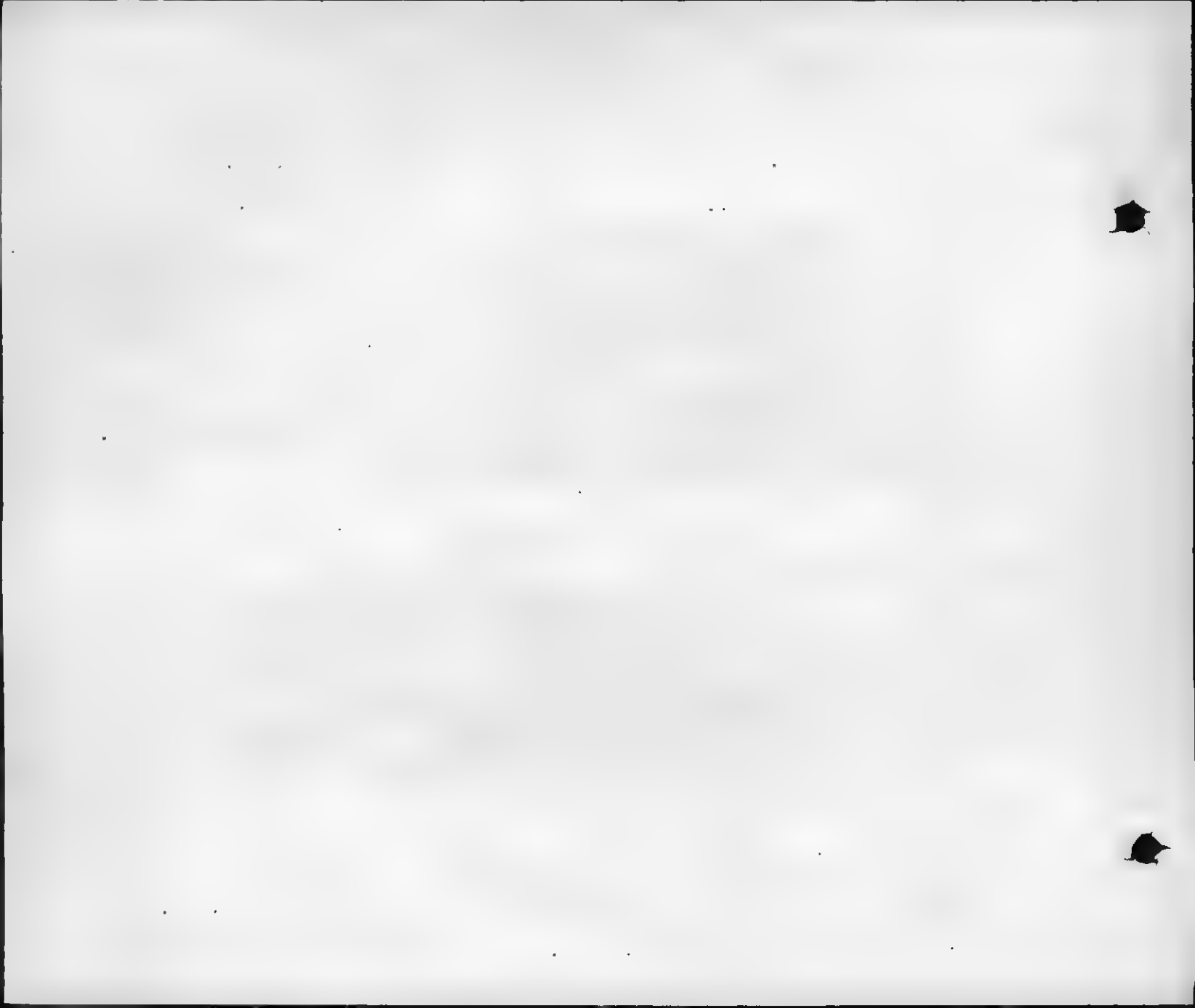
may be required by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

10591

10583

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park, Md.</b>				c. LENGTH OF STAY IN 1b <b>1 year</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8405 Patuxent avenue, .</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Ephriam</b> Last <b>Pannebaker</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>30</b> Year <b>19 61-</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 20, 1909</b>		9. AGE (In years last birthday) yrs. <b>51</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Social Security</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D C</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Gustave B Pannebaker</b>				14. MOTHER'S MAIDEN NAME <b>Mamie Jacobs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Helen E Pannebaker</b> Address <b>College Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 72011 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO (c) <b>Reperme</b>						INTERVAL BETWEEN ONSET AND DEATH <b>15'</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1948</b> , to <b>Sept 19 1961</b> , that (I) (we) last saw the deceased alive on <b>9-22 1961</b> , and that death occurred at <b>11 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>W. L. Etienne</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>10-1-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. L. ETIENNE</b>				22d. ADDRESS <b>4713 Berwyn Rd College Park</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct 4, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Md.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 2 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

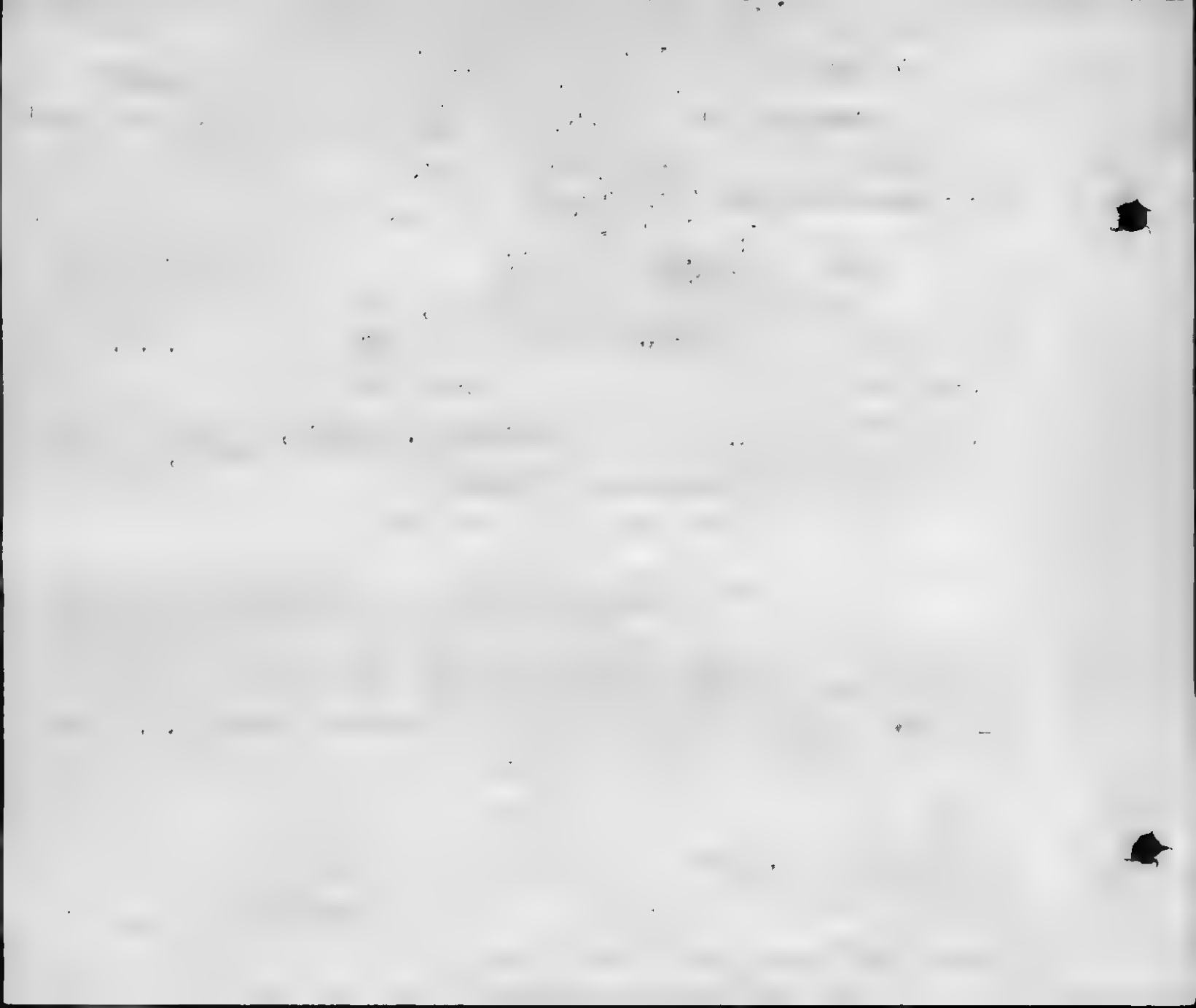
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10592

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10584

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		c. LENGTH OF STAY IN TB <b>Transient</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>In a wooded area back of his home</b>		e. STREET ADDRESS <b>Good Luck Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Hugh</b> Middle <b>Carter</b> Last <b>Paris</b>		4. DATE OF DEATH Month <b>September</b> Day <b>6</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1909</b>
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR: Months <b>52</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railway Express Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Paris</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Suit</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Winifred T. Baldwin, 6034 Telegraph Rd Lanham, Md</b>	
17. INFORMANT <b>Winifred T. Baldwin, 6034 Telegraph Rd Lanham, Md</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and Shock</b> DUE TO (b) <b>Shot Gun Wound of the Head</b> DUE TO (c) <b>176X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Went to the edge of the woods and shot self</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. TIME OF INJURY Month, Day, Year <b>9/6/ 61</b> Hour a.m. <b>12</b> x	
20c. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>In a wooded area Lanham P.G. Md</b>	
20e. (City or town) <b>Lanham</b>		20f. (County) <b>P.G.</b>	
20g. (State) <b>Md</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL EXAMINER'S NAME (Type) <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>9/6/61</b>		Address (Street, city, town, or county) <b>Colmar Manor, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/9/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or country) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Maryland</b>		24. REC'D BY REGISTRAR <b>SEP 8 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

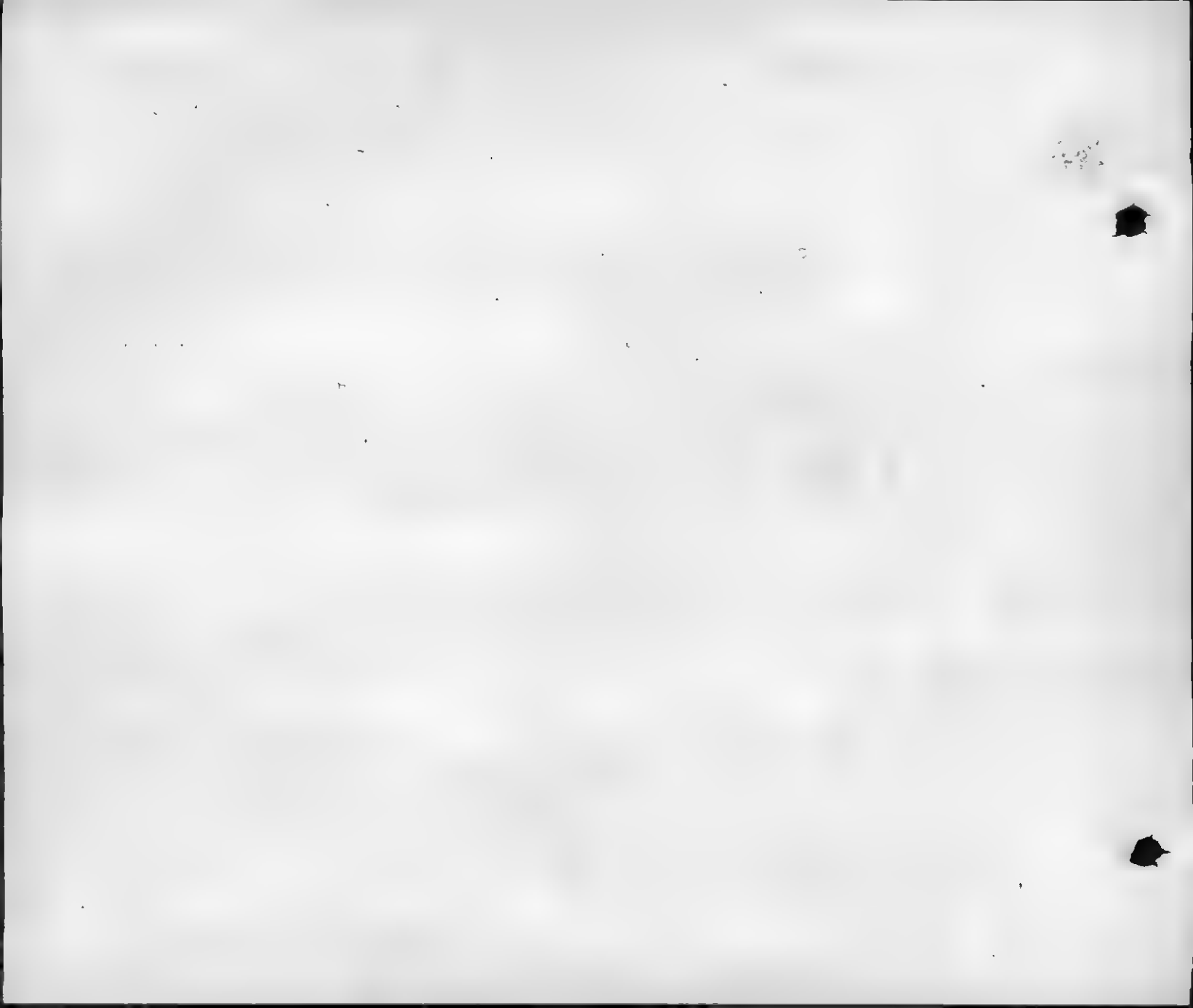


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
4  
10593  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>		c. LENGTH OF STAY IN 1b <b>University Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eleven Cedars</b>		d. STREET ADDRESS <b>4336 Claggett Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>L.</b> Last <b>Parsons</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>24,</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 22, 1870</b>
9. AGE (In years and birthday) <b>90</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13. BIRTHPLACE (State or foreign country) <b>Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. FATHER'S NAME <b>Christopher Buttner</b>		16. MOTHER'S MAIDEN NAME <b>Rebecca Stanzey</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		18. SOCIAL SECURITY NO. <b>Albert B. Parsons Same as #2 Son</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>Decomposition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2 - 4</b> <b>1960</b> to <b>9 - 24</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>9 - 22</b> <b>1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>A. B. Parsons</b>		22b. DATE SIGNED <b>SEP 27 '61</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. B. Parsons</b>		22d. ADDRESS <b>Hyattsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/26/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>SEP 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Carlton L. Howard</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10594

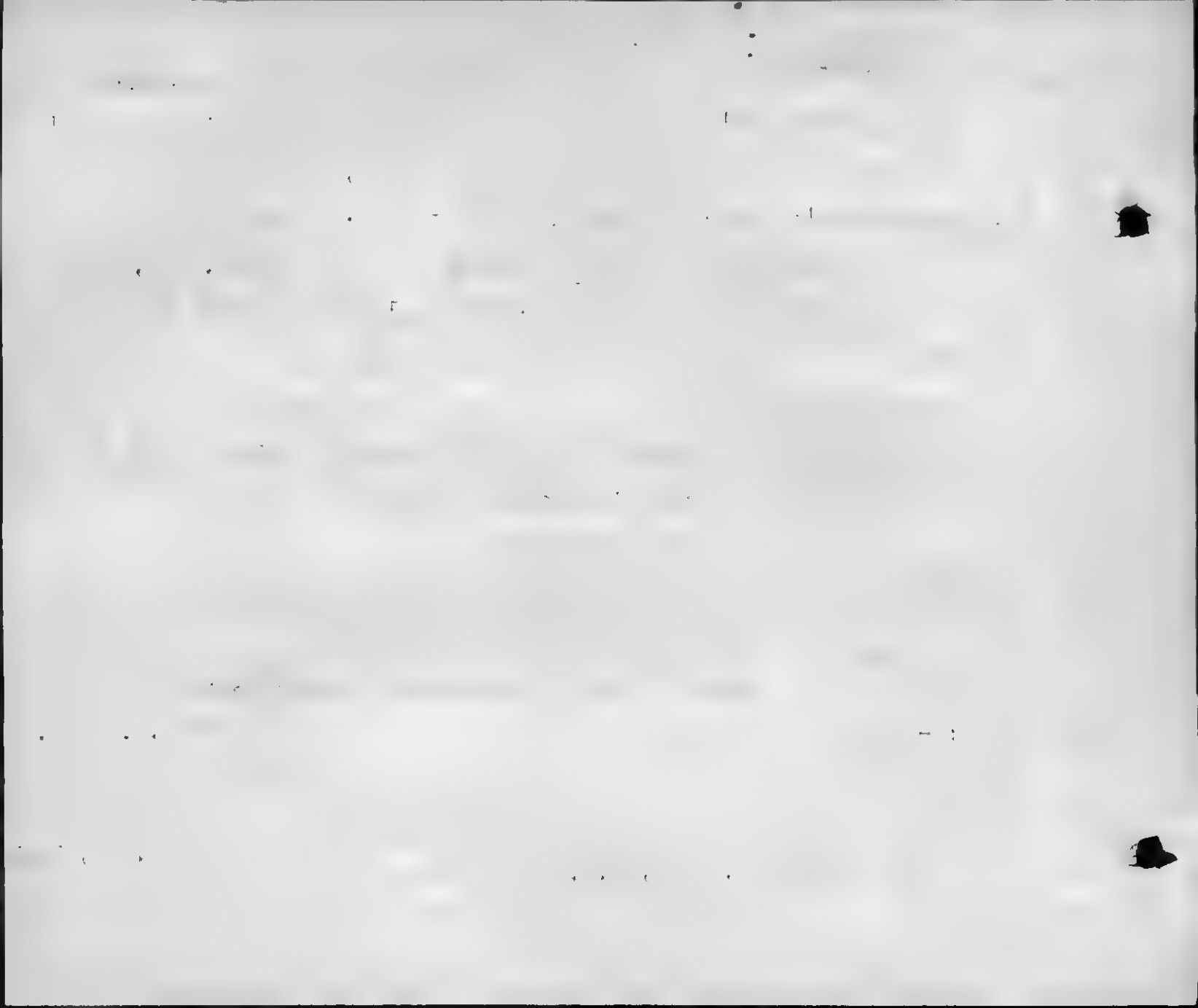
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10586

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bellemead, Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		e. STREET ADDRESS <b>4000 - 74th. Place</b>	
3. NAME OF DECEASED (Type or print) <b>Loretta Lynn Paugh</b>	4. DATE OF DEATH Last First Middle <b>Sept. 10, 1961</b>	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Last First Middle <b>June 20, 1961</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years, last birthday) yrs. <b>2</b> Months <b>21</b> Days <b>10</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Guy William Paugh</b>	14. MOTHER'S M.A.DEN NAME <b>Mary Jo Hallisey</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mary Jo Hallisey</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to</b> <b>Suffocation</b> DUE TO (b) <b>7-4-0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Suffocation</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Caught between mattress and side of crib</b>	
20c. TIME OF INJURY Month, Day, Year Hour, e.m. <b>7:20 p.m. 9/10 1961</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Hyattsville P.G. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		DATE SIGNED <b>Sept. 10, 1961</b>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-13-1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 13 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

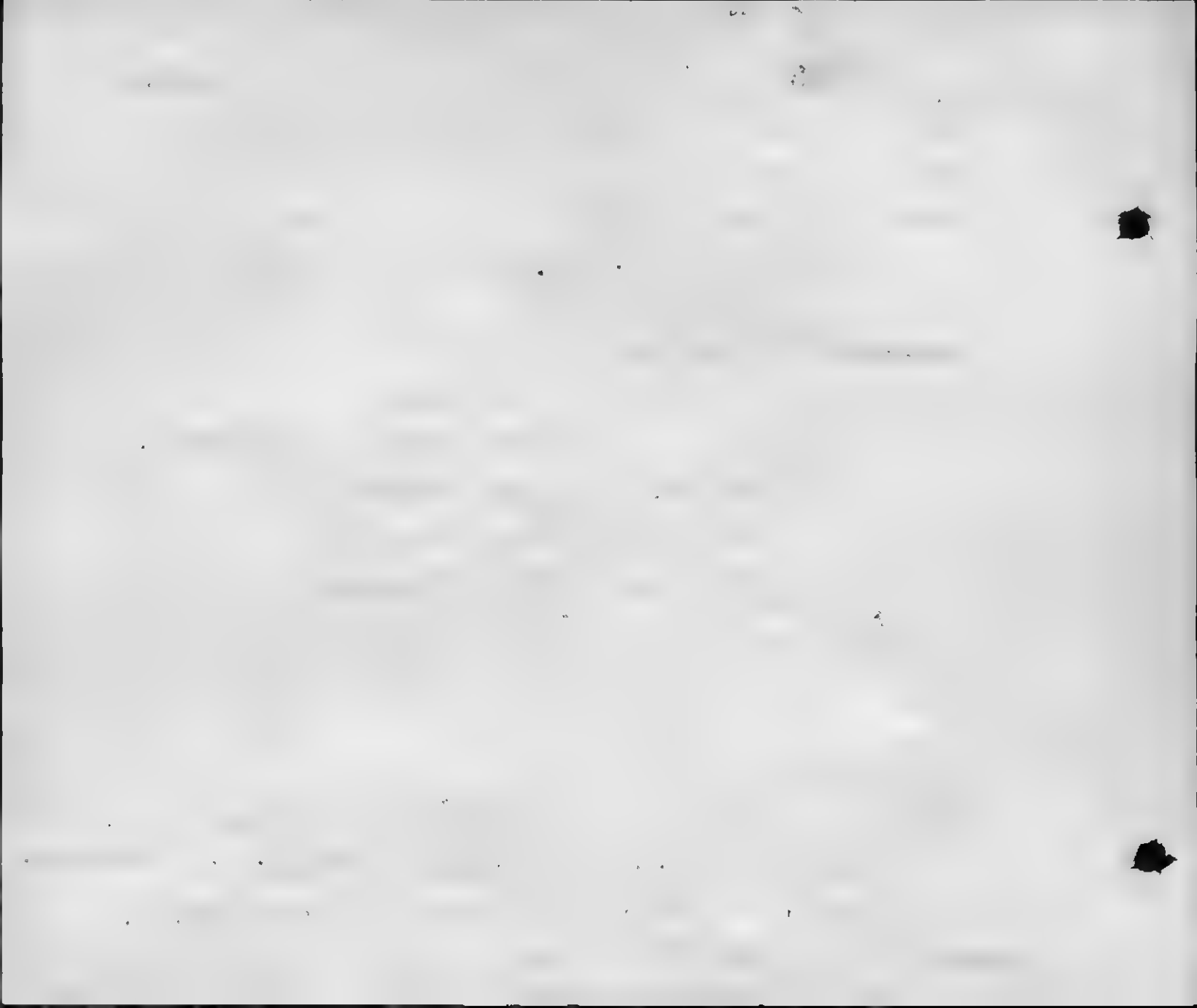
10595

10587

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u> d. STREET ADDRESS <u>5437 Taussig Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Anna K. Pfeifer</u>		<b>4. DATE OF DEATH</b> Month <u>September</u> Day <u>1</u> Year <u>1961</u>		<b>5. SEX</b> <u>Female</u>	
<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>January 26, 1918</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>own home</u>		<b>11. BIRTHPLACE</b> (Country & State, or foreign country) <u>Pa</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U S A</u>		<b>13. FATHER'S NAME</b> <u>Ralph Denniston</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Eates</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Fred D Pfeifer</u> Address <u>Bladensburg Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> (b) <u>Ventricular fibrillation</u> (c) <u>Chronic thyrotoxicosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Azotemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>8/18</u> 19<u>61</u> to <u>8/31</u> 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>8/31</u> 19<u>61</u>, and that death occurred at <u>9:30</u> AM, from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Barry Rosenberg</u>		<b>22b. DATE SIGNED</b> <u>September 1, 1961</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Barry Rosenberg, M.D.</u>	
<b>22d. ADDRESS</b> <u>1210 Chillum Manor Rd., W. Hyattsville, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Sept 5, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Gate of Heaven Cemetery</u>	
<b>23d. LOCATION (City, town or county)</b> <u>Silver Springs, Md.</u>		<b>(State)</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Basel's Funeral Home</u>		<b>25a. REC'D BY REGISTRAR</b> <u>SEP 7 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

VR A15 (4)  
 15M 9/60



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10596

**CERTIFICATE OF DEATH**

Item 0 & Y 111111 9/25/61 - iwk

10588

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2619 Nicholson st		d. STREET ADDRESS 2619 Nicholson 1	
3. NAME OF DECEASED (Type or print) First Middle Last Frances Preikszas		4. DATE OF DEATH Month Day Year Sept 13 1961	
5 SEX Female	6 COLOR OR RACE wh	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1903 Aug 22, 1908 58 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11 BIRTHPLACE (State or foreign country) Minnesota
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Mary ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Otto J Preikszas Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Carcinoma of rectum with Metastasis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 15 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 10-27 1961, to 9-11 1961, that (we) last saw the deceased alive on 8-11 1961, and that death occurred at 5:42 A.M. from the causes and on the date stated above.			
22a. SIGNATURE [Signature] M.D.		22b. ADDRESS 9-13-61	
22c. PHYSICIAN'S NAME (Type) ROYLAND F. WILKINSON M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept 15, 1961	23c. NAME OF CEMETERY OR MEMORY Arlington National	23d. LOCATION (City, town or county) (State) Arlington Va
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE SEP 18 '61	
ADDRESS Hyattsville Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kram	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

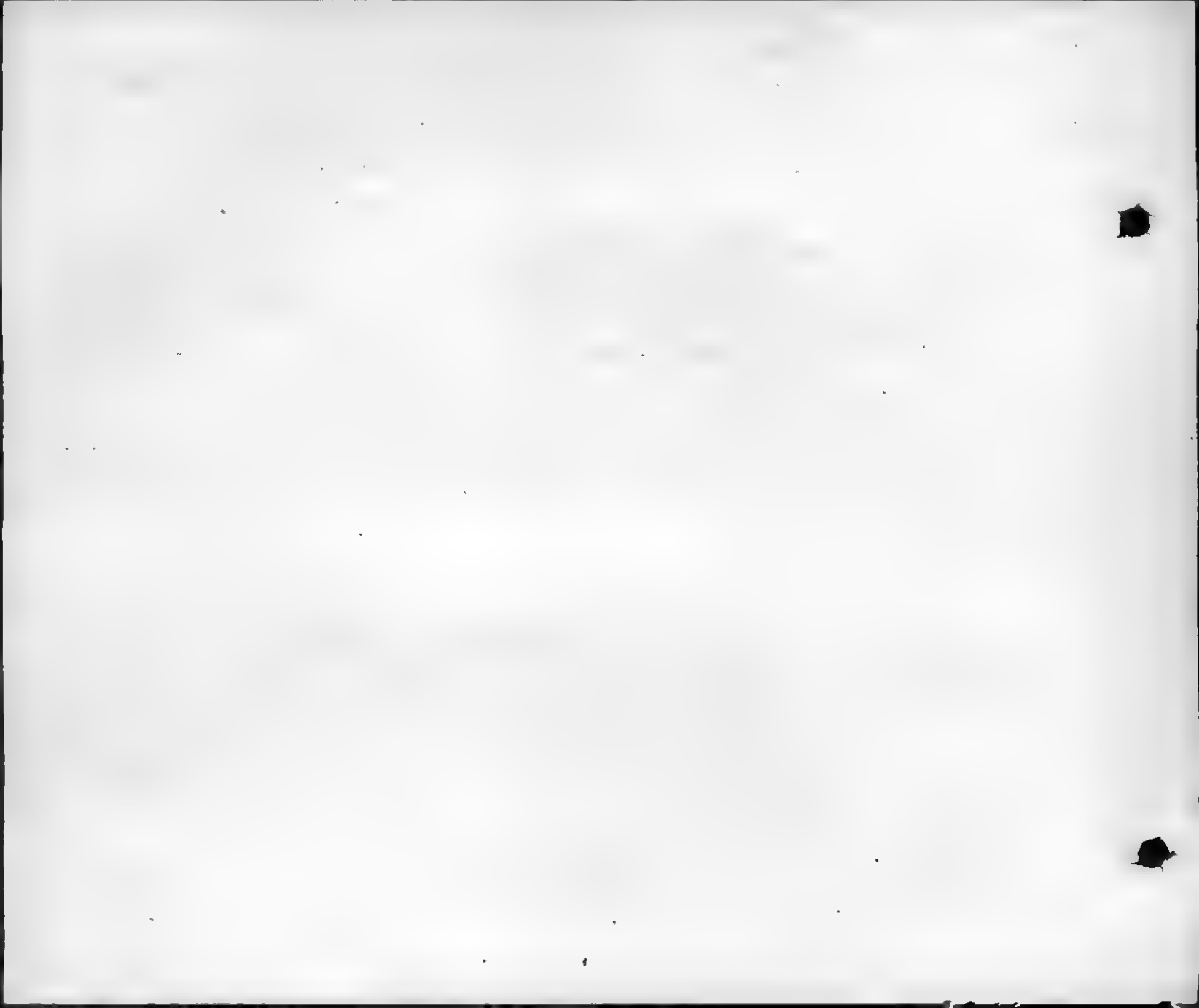
VS A15 (4)  
15M 9/58

# 1 10597 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

Reg. Dist. No. 10589

1 PLACE OF DEATH a. COUNTY Pr. George Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Hgts.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home		d. STREET ADDRESS 2349 Iverson St. S. E.	
3 NAME OF DECEASED (Type or print) First Catherine Middle E. Last Quigley		4. DATE OF DEATH Month Sept. Day 12, Year 19 61	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 5, 1880
9 AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Wash. Term. Co.	
11. BIRTHPLACE (State or foreign country) Wash. D. C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Quigley		14. MOTHER'S MAIDEN NAME Rose Dougherty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. No	
INFORMANT Mary Quigley		Address 2349 Iverson St. S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure			
4 - 1 DUE TO (b) Arteriosclerotic Cardiovascular Disease			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1955, to 9/12, 1961, that I last saw the deceased alive on 9/19, 1961, and that death occurred at 4:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David Lenarduzzi M.D.		ADDRESS (Street, city or town, state) 2901 Fairlawn St SE Wash, D.C.	
DATE SIGNED 9/12/61			
PHYSICIAN'S NAME (Type) David Lenarduzzi		Wash, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 15, 1961	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.		ADDRESS 317 Penna. Ave. S.E.	
24a. REC'D BY REGISTRAR DATE SEP 15 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hane	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10598

10590

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1602 Montgomery St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>602 Montgomery St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lloyd Sewell Guyon</u>		4. DATE OF DEATH <u>September 28 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>radio engineer F.C.C.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Philadelphian Pa</u>	
13. FATHER'S NAME <u>Samuel Wayne Guyon</u>		14. MOTHER'S MAIDEN NAME <u>Elinabeth Hoarer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes WWI</u>		16. SOCIAL SECURITY NO. <u>6204 Huntington</u>	
17. INFORMANT <u>Russell H. Guyon Newport News Va</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Coronary artery thrombosis</u>	
		(c) <u>Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiomegaly</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 18, 1961</u> to <u>Sept 28, 1961</u> , that I last saw the deceased alive on <u>Sept 18, 1961</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank Weaver</u>		ADDRESS (Street, city or town, state) <u>320 Montgomery St, Laurel, Md</u>	
PHYSICIAN'S NAME (Type) <u>FRANK WEAVER</u>		DATE SIGNED <u>10/1/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 2, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Connelley</u>		24a. REC'D BY REGISTRAR <u>OCT 4 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hane</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 10599 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1  
FOR STATE  
HEALTH DEPT.

M

1. PLACE OF DEATH  
a. COUNTY

PRINCE GEORGES MARYLAND

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)  
c. LENGTH OF STAY IN 1b

CHEVERLY

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

PRINCE GEORGES GENERAL

3. NAME OF DECEASED  
(Type or print)

CHARLES ALBERT RICHARDSON

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

JUNE 13, 1888

9. AGE (In years last birthday)

73

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FARMER

10b. KIND OF BUSINESS OR INDUSTRY

FARMING

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN William RICHARDSON

14. MOTHER'S MAIDEN NAME

ELLEN ELIZABETH BALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT Address  
MARIE RICHARDSON, BRANDYWINE, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

12010 DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

Cardiac failure

Arteriosclerotic Heart disease

INTERVAL BETWEEN ONSET AND DEATH

inst 4 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):

Cerebral accident

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING CAUSE OF DEATH ☒

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY  
Hour a.m. p.m. 19

20d. INJURY OCCURRED  
While at work ☐ While not at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Dayton Watkins

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

9-14-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

9-17-61

22c. NAME OF CEMETERY OR CREMATORY

ST PAULS

22d. LOCATION (City, town, or country)

BADEN, MARYLAND

(State)

23. FUNERAL DIRECTOR

The HUNTT FUNERAL HOME, WALDORF, MD.

24a. REC'D BY REGISTRAR

DATE SEP 20 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kumpf

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed in by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10600 CERTIFICATE OF DEATH 10593

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN b. <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D. C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> d. STREET ADDRESS <u>8200 Largo Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Vincent Richardson</u>		4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-25-98</u>	
9. AGE (in years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR: Months <u>62</u> Days <u>62</u> Hours <u>62</u> Min. <u>62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Share-cropper</u>	
11. PLACE (County & State, or foreign country) <u>Prince George's Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Richardson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>12X</u>	
17. INFORMANT <u>Mrs. E Josephine Richardson, Wife</u>		Address <u>Prince George's Co. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Electrolyte Imbalance</u> <u>Ch. renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>12X</u> DUE TO (c) <u>Ch. renal disease</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>9/17/61</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>5300</u>		20f. (City or town) <u>College Park</u> (County) <u>Md.</u> (State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>9/17/61</u> to <u>9/18/61</u> , that (I) (we) last saw the deceased alive on <u>9/17/61</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Louisa Mendel</u> M.D.		22b. ADDRESS <u>4506 COLLEGE AVE</u>	
22c. PHYSICIAN'S NAME (Type) <u>LOUISA MENDEL, M.D.</u>		22d. ADDRESS <u>COLLEGE PARK</u> Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/21/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Family Cemetery</u>		23d. LOCATION (City, town or county) <u>Mitchville, Maryland</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Kneass</u>		25a. REC'D BY REGISTRAR <u>SEP 20 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Kneass</u>		25c. DATE <u>SEP 20 '61</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1  
FOR STATE  
HEALTH DEPT.

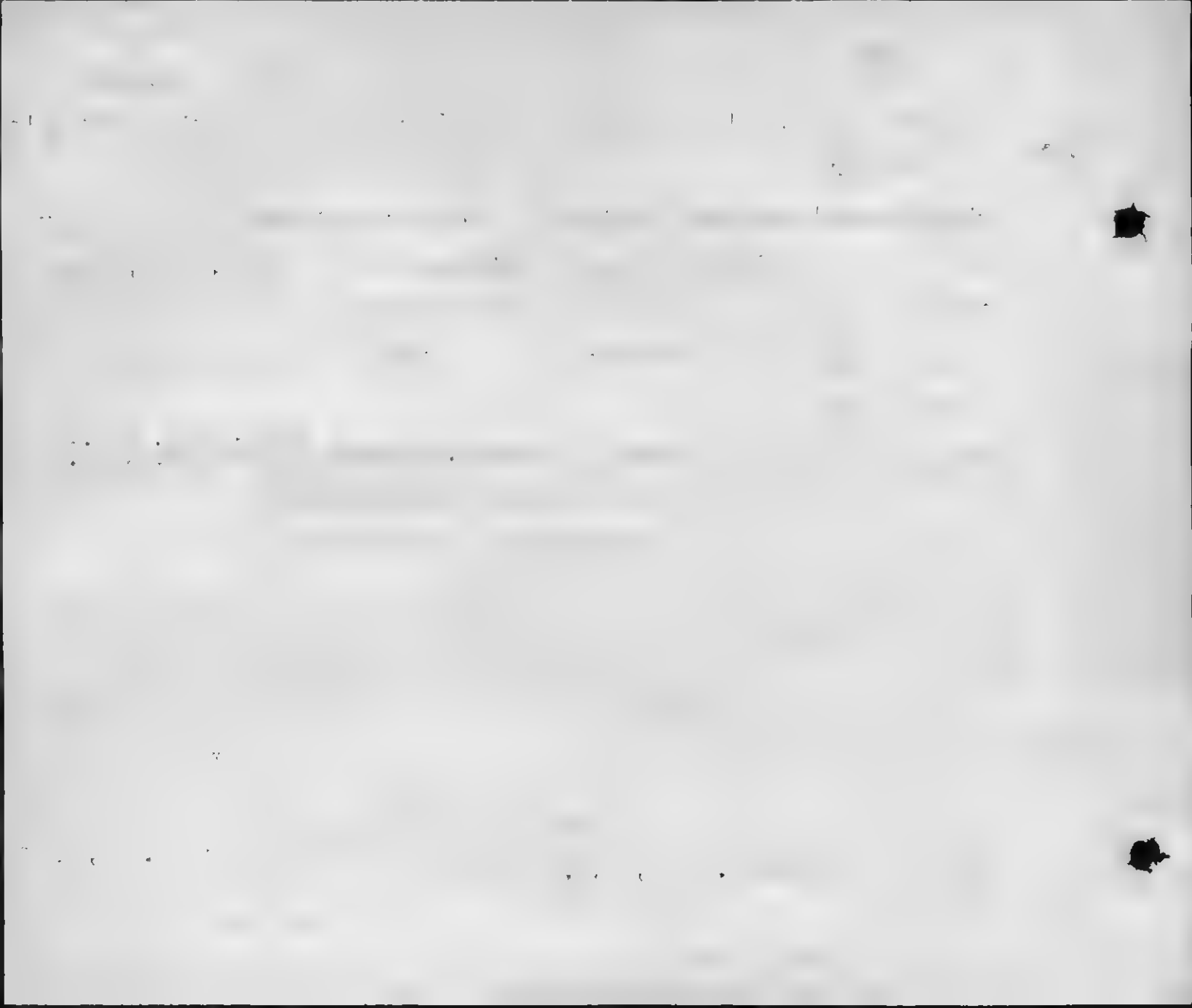
10601

Item 22a File 6295 9/10/61 jwk

10594

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; not before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kentland</b>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <b>7710 Greeley Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Louise Mary Rithman</b>	4. DATE OF DEATH <b>Sept. 12, 1961</b>	f. AGE (In years last birthday) <b>74</b> yrs. IF UNDER 1 YEAR: Months <b>12</b> Days <b>19</b> Hours <b>61</b> Min.	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1887</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Yours</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Harry R. Rithman</b>		Address <b>3500 - 37th. Ave., Colmar Manor, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442 X</b> <b>Acute congestive heart failure</b> DUE TO (b) <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>Diabetes</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-15-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Charles</b>		22d. LOCATION (City, town, or country) <b>Md.</b>	
23. FUNERAL DIRECTOR <b>Timothy Hanlon</b> ADDRESS <b>Fun Ho 3831 64 Ave n 4</b>		24a. REC'D BY REGISTRAR <b>SEP 14 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>James I. Boyd</b>		DATE <b>SEP 14 '61</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

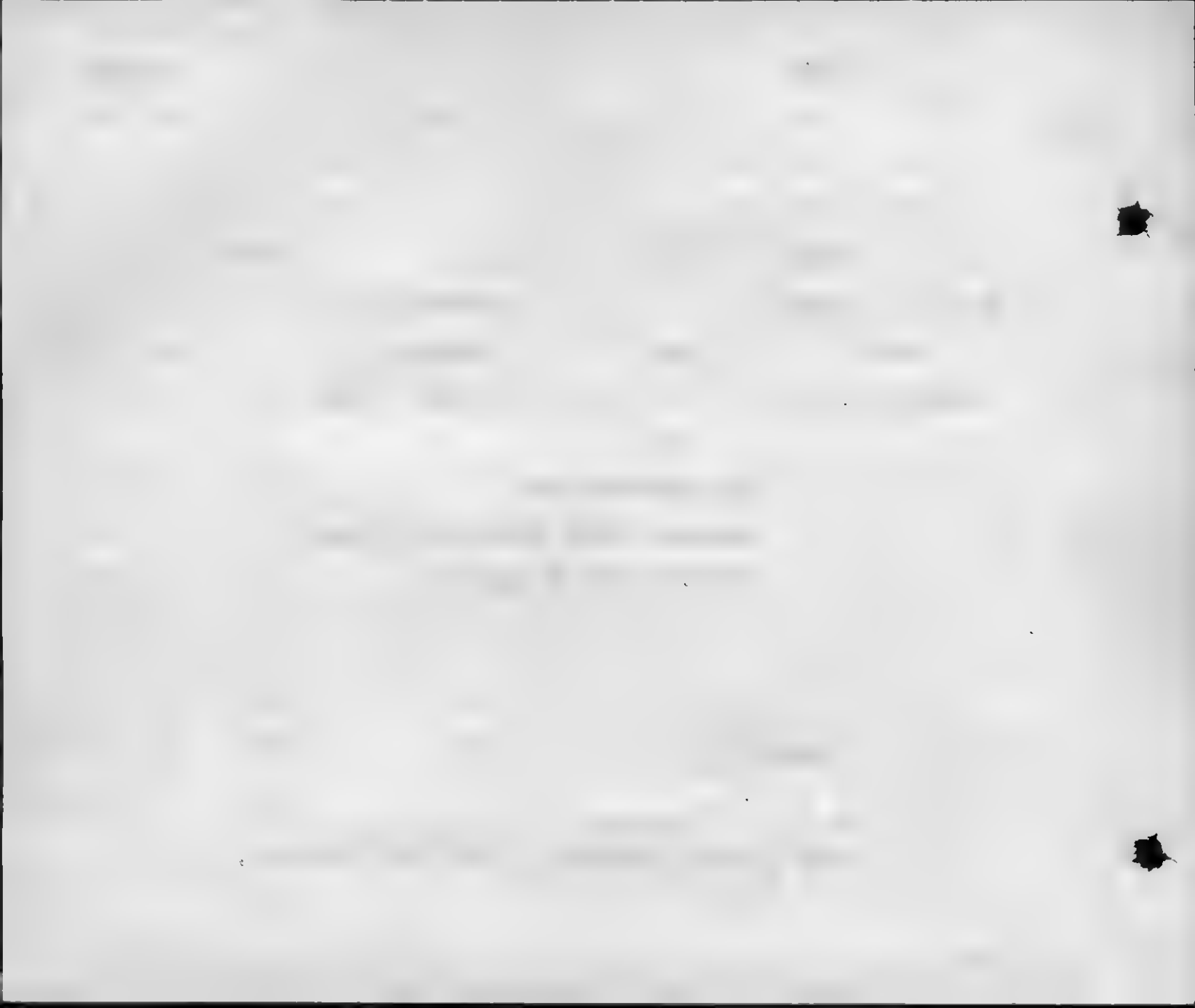
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<b>1. PLACE OF DEATH</b> a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN IT <b>18 HRS 30 MIN</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>US AIR FORCE HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAPITOL HEIGHTS</b> d. STREET ADDRESS <b>615 49TH AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <b>TERRY LEA ROBINSON</b>		<b>4. DATE OF DEATH</b> Month <b>SEPTEMBER</b> Day <b>17</b> Year <b>19 61</b>		<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>CAUCASIAN</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>16 SEPTEMBER 1961</b>		<b>9. AGE</b> (In years last birthday) <b>18</b> <b>30</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>NONE</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>NONE</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND UNITED STATES</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>UNITED STATES</b>	
<b>13. FATHER'S NAME</b> <b>JAMES A ROBINSON</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>MARJORIE L YOYK</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> <b>16. SOCIAL SECURITY NO.</b> <b>NONE</b> <b>17. INFORMANT</b> Address _____							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)</b> <b>RESPIRATORY FAILURE</b> (b) <b>POSSIBLE CENTRAL NERVOUS SYSTEM DAMAGE</b> (c) <b>DIFFICULT LABOR AND DELIVERY</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> _____												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 HOURS</b> <b>18 HOURS</b> <b>18 HOURS</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) _____												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____		<b>(County)</b> _____		<b>(State)</b> _____					
<b>21. I certify that (1) <del>DOUGLAS</del> attended the deceased from <b>16 SEPT</b> to <b>17 SEPT</b>, 19 <b>61</b>, that (1) <del>XX</del> last saw the deceased alive on <b>17 SEPT</b>, 19 <b>61</b>, and that death occurred at <b>745A</b>, from the causes and on the date stated above.</b>												<b>22b. DATE</b> <b>17 SEP 61</b>			
<b>22a. SIGNATURE</b> <i>Richard P Malsan</i> M.D.				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>				<b>22b. ADDRESS</b> <b>USAF HOSP, ANDREWS AFB, WASH 25 DC</b>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>RICHARD P MALSAN CAPT USAF MC</b>				<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>											
<b>23b. DATE THEREOF</b> <b>21 SEPT. 1961</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>BATH MAINE</b>				<b>23d. LOCATION (City, town or county)</b> _____							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Russell Funeral Home Inc</i>				<b>ADDRESS</b> <b>816 H ST. N.E. DC</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE SEP 21 '61</b>							
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hines</i>															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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 15M 9/60



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**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

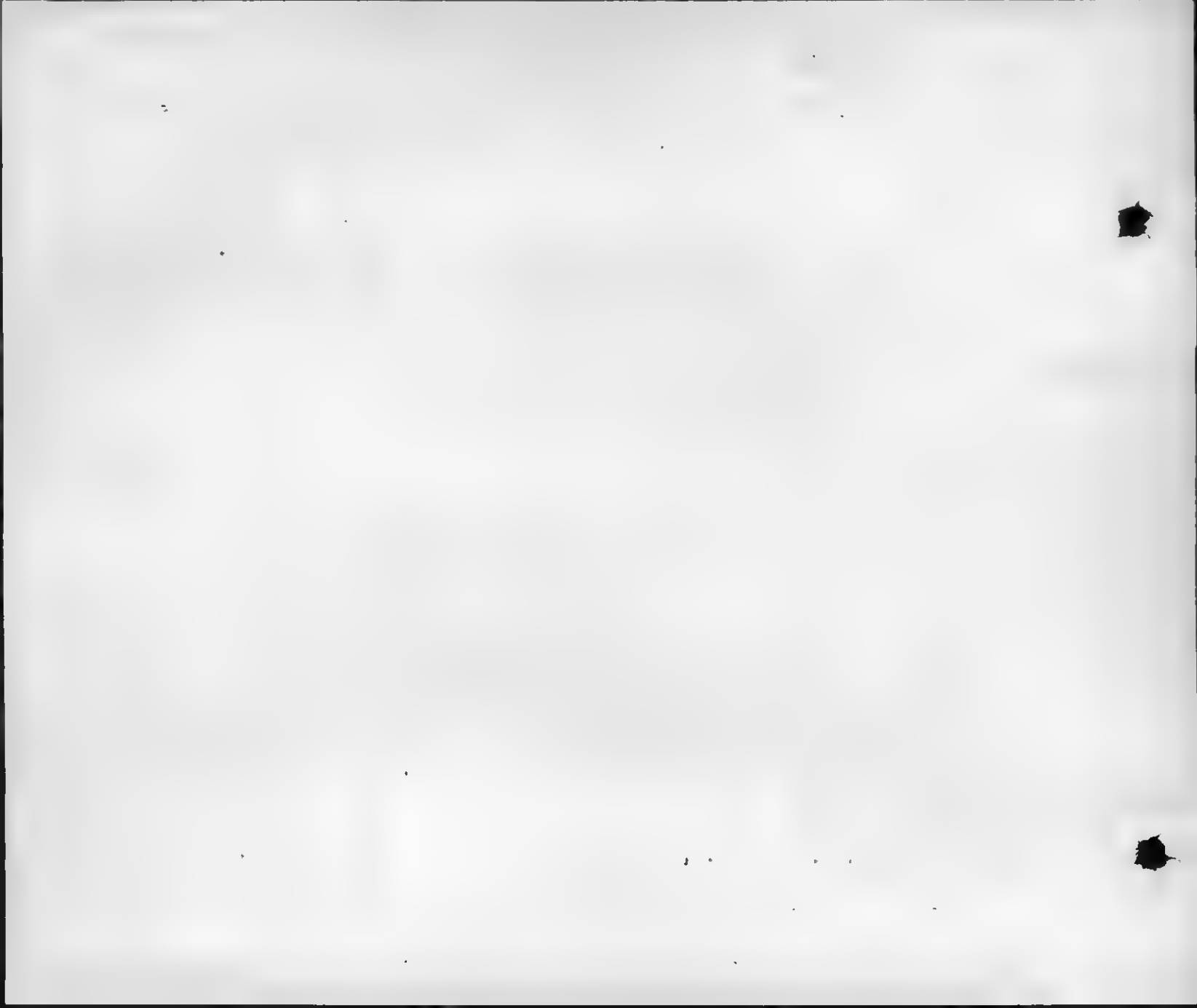
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10603

**CERTIFICATE OF DEATH**

Items 11, 12, 13 & 14 File 8294 9/8/61 1st

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived if in institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1/2 hr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 62 Hyattsville	
f. STREET ADDRESS 1 4105 Kennedy Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edwin First Middle Last Rodman		4. DATE OF DEATH Month Sept. Day 2 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Nov 1900
9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter Reader		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward P. Rodman		14. MOTHER'S MAIDEN NAME Alice Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic occlus. Rhe. Ar.</i> + 20.5 DUE TO (b) <i>Arteriosclerotic Hb. Cris</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-1-1961 to 9-2-1961, that (I) (we) lost saw the deceased alive on 9-2-1961, and that death occurred at 3:00 AM from the causes and on the date stated above.			
22a. SIGNATURE <i>A. Deitz</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. A. Deitz M.D.		22d. ADDRESS Hyattsville., Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/5/61	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City, town, or county) (State) Bladensburg Maryland
24. FUNERAL DIRECTOR'S SIGNATURE <i>Real Funeral Home</i>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
ADDRESS 4512 G. Ave. WASH, D.C.		DATE SEP 5 '61	



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FOR STATE  
HEALTH DEPT  
(M)  
X  
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TO DEPT. 22 MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10604  
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 10587

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY Prince George's MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill  
c. LENGTH OF STAY IN 1b 30 minutes  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ABC Drive In

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)  
a. STATE Maryland b. COUNTY Prince George  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville  
d. STREET ADDRESS 5438 Spring Street

3. NAME OF DECEASED (Type or print) First Middle Last  
Hattie Pearl Rowe  
4. DATE OF DEATH Month Day Year  
September 23, 1961

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐  
8. DATE OF BIRTH Aug. 25, 1905 9. AGE (In years less birthday) 56 yrs.  
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman 10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. 11. BIRTHPLACE (State or foreign country) IOWA 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Walter W. LaMaster 14. MOTHER'S MAIDEN NAME Madden Kilgore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT 5645 Maxwell Drive  
Walter W. Rowe, Washington 23, D.C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 4 INFARCT HEART  
(b) DUE TO CORONARY THROMBOSIS  
(c) DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☒

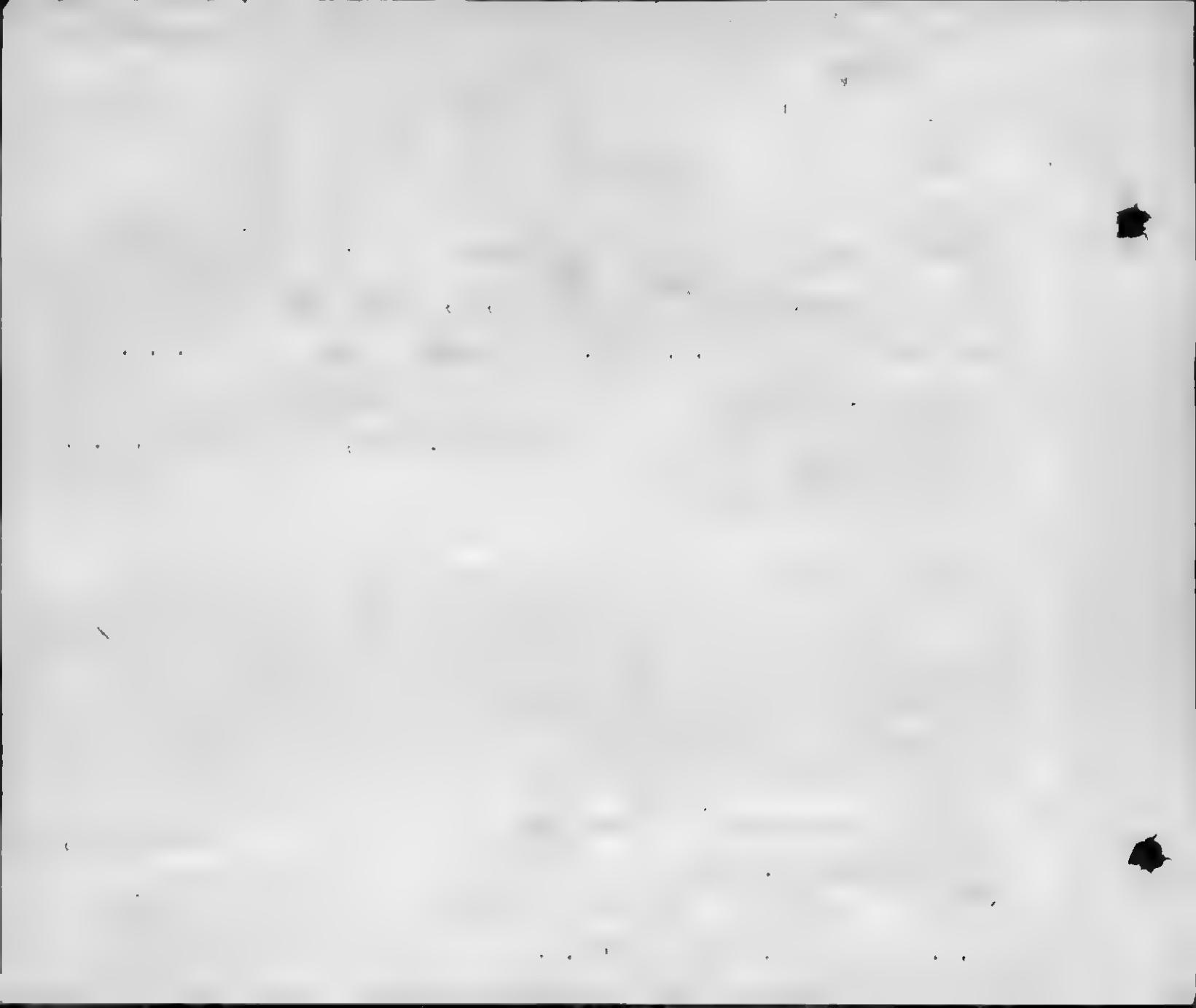
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE James I. Boyd M.D. CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) James I. Boyd ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED September 24, 1961  
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, or other disposition of remains Burial 22b. DATE THEREOF 9/27/61 22c. NAME OF CEMETERY OR CREMATORY Arlington National 22d. LOCATION (City, town, or county) (State) Arlington, Virginia

23. FUNERAL DIRECTOR W.W. Chambers Co. Washington D.C. ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE  
DATE SEP 26 '61



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

VS. AISME  
SM 9160

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10605

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10598

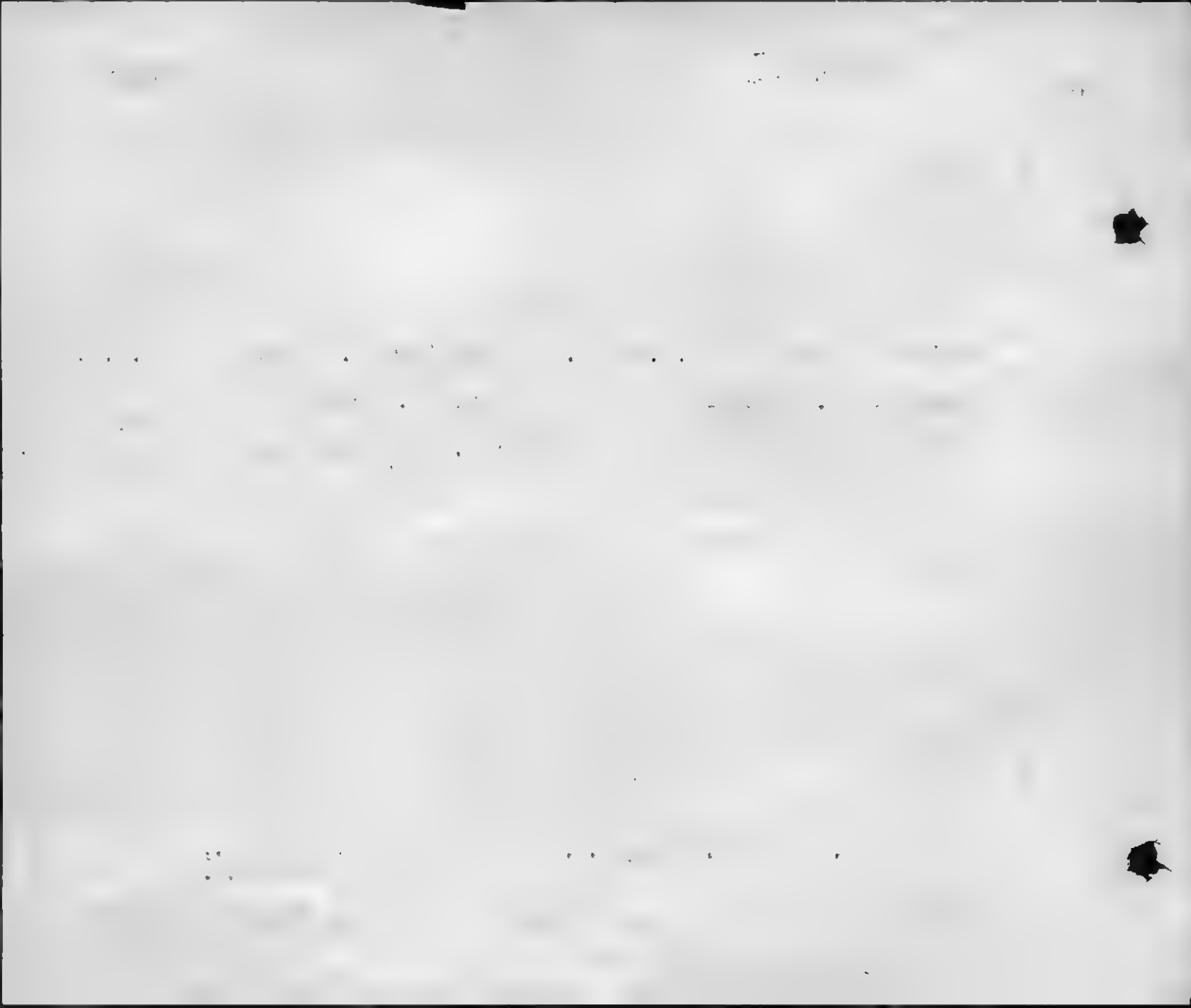
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burtonsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		d. STREET ADDRESS <b>14910 Columbia Road</b>	
3. NAME OF DECEASED (Type or print) <b>Sante</b>	4. DATE OF DEATH <b>September 9, 1961</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 15, 1870</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. FATHER'S NAME <b>Antonino Santini</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>Eurosia Grilli</b>	
15. SOCIAL SECURITY NO. <b>None</b>		16. INFORMANT <b>Anthony P. Santini</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of the right Hip</b> DUE TO Conditions, any, which gave rise to immediate cause (b) <b>Terminal pneumonia</b> (c) <b>None</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Fell walking in the bathroom</b>		18. INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <b>Primary</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell walking in the bathroom</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:00 a.m. 9/5/61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Burtonsville</b> (County) <b>Montgomery</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 12, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Marys Cem.</b>		22d. LOCATION (City, town, or country) <b>Laurel, Maryland</b>	
23. FUNERAL DIRECTOR <b>Mc Witt</b>		24a. REC'D BY REGISTRAR <b>SEP 15 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Donaldson</b>		DATE <b>Sept. 9, 1961</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3  
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10606  
CERTIFICATE OF DEATH  
10599

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PRINCE GEORGE'S GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE'S</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WEST HYATTSVILLE</u> d. STREET ADDRESS <u>6923 15TH AVENUE</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First Middle Last 4. DATE OF DEATH <u>SEPT. 23 1961</u> Month Day Year		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>JUNE 4, 1871</u> 9. AGE (In years last birthday) <u>90</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Guard</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govlt.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Fauquier Co. Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Leverett J. Saunders</u> 14. MOTHER'S MAIDEN NAME <u>Lucy V. Lomax</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Ethel L. Saunders</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 162.1 } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Bronchogenic Carcinoma (right lower lobe)</u> (c), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>unknown</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (i) (this hospital) attended the deceased from <u>9/21/61</u> to <u>9/23</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>9/23</u> , 19 <u>61</u> , and that death occurred at <u>11:30</u> P. M. from the causes and on the date stated above.	
22a. SIGNATURE <u>Samuel J. Sugar</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Dr. Samuel J. Sugar, M.D.</u>		22b. DATE SIGNED 22d. ADDRESS <u>4637 Eastern Ave., Washington, 18 D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9/26/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u> 23d. LOCATION (City, town or county) (State) <u>Bladensburg Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 26 1961</u> 25b. REGISTRAR'S SIGNATURE <u>Charles S. Kram</u>	



## CERTIFICATE OF DEATH

10600

1. PLACE OF DEATH a. COUNTY		Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE		Maryland		b. COUNTY		✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cheverly		c. LENGTH OF STAY IN 1b		4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore		3501-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Prince Georges General Hospital		d. STREET ADDRESS		4204 Harford Terrace		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day	
Lilly						Schmidt		Sept.		3		19 61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White				23 July 1883		78		Months		Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
None		At Home		Baltimore Maryland		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Christian Schmidt		Emilie Toebeke											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT		4204 Harford Terrace Balto. 14, MD.							
no		none		MISS MARGUERITE SCHMIDT									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) + 20. sclerosis Ht des. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
				Hour a.m. p.m. 19		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 30 Aug. 1961 to 3 Sept. 1961 that (I) (we) last saw the deceased alive on 3 Sept. 1961, and that death occurred at 3, 15, 16 from the causes and on the date stated above		22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
		Thomas J. Maloney		3 Sept 61		Dr. T. Maloney, M.D.		4817 71st Ave. Landover Hills, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)					
BURIAL		9/6/61		BALTIMORE CEMETERY		BALTIMORE MARYLAND							
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
HENRY SANDER & SONS INC. BALTO. MD.				DATE SEP 6 '61		Arthur S. Kraus							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director. After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

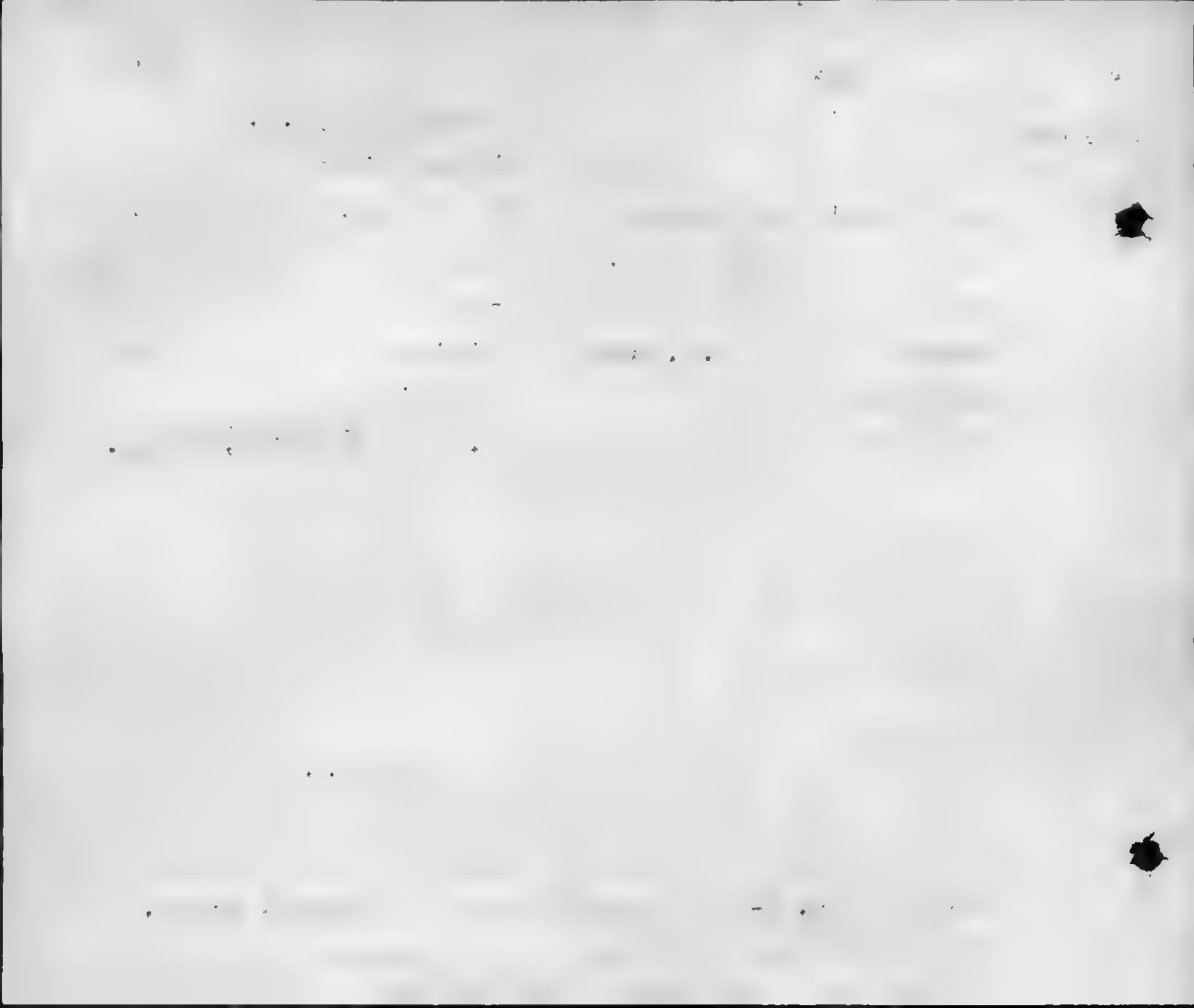
VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10601

10608

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>20 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Wilma</b>		First <b>Wilma</b>		M. date <b>0.</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>G. C. Murphy</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Owen Obaugh</b>		14. MOTHER'S MAIDEN NAME <b>Etha Williams</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give number of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Louise V. Frye</b>		17. INFORMANT <b>7414 Varnum Street Hyattsville, Maryland.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral</b> 241X DUE TO <b>3rd lung</b> Conditions, if any, which gave rise to immediate cause (b) <b>Bronchial Asthma</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> , 19 <b>9/19</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9/19</b> , 19 <b>61</b> , and that death occurred on <b>12:30 A.M.</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Leon R. Levitsky</b>		22b. DATE SIGNED <b>9/20/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Leon R. Levitsky</b>	
22d. ADDRESS <b>3408 R. &amp; Ave Mt. Rainier, Md.</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 23- 61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
23d. LOCATION (City, town or county)		23e. (State)		23f. (County)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>SIMMONS BROS</b>		24a. ADDRESS <b>1661 Gooch Road</b>		24b. DATE <b>SEP 25 '61</b>	
24c. (City, town or county)		24d. (State)		24e. (County)	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

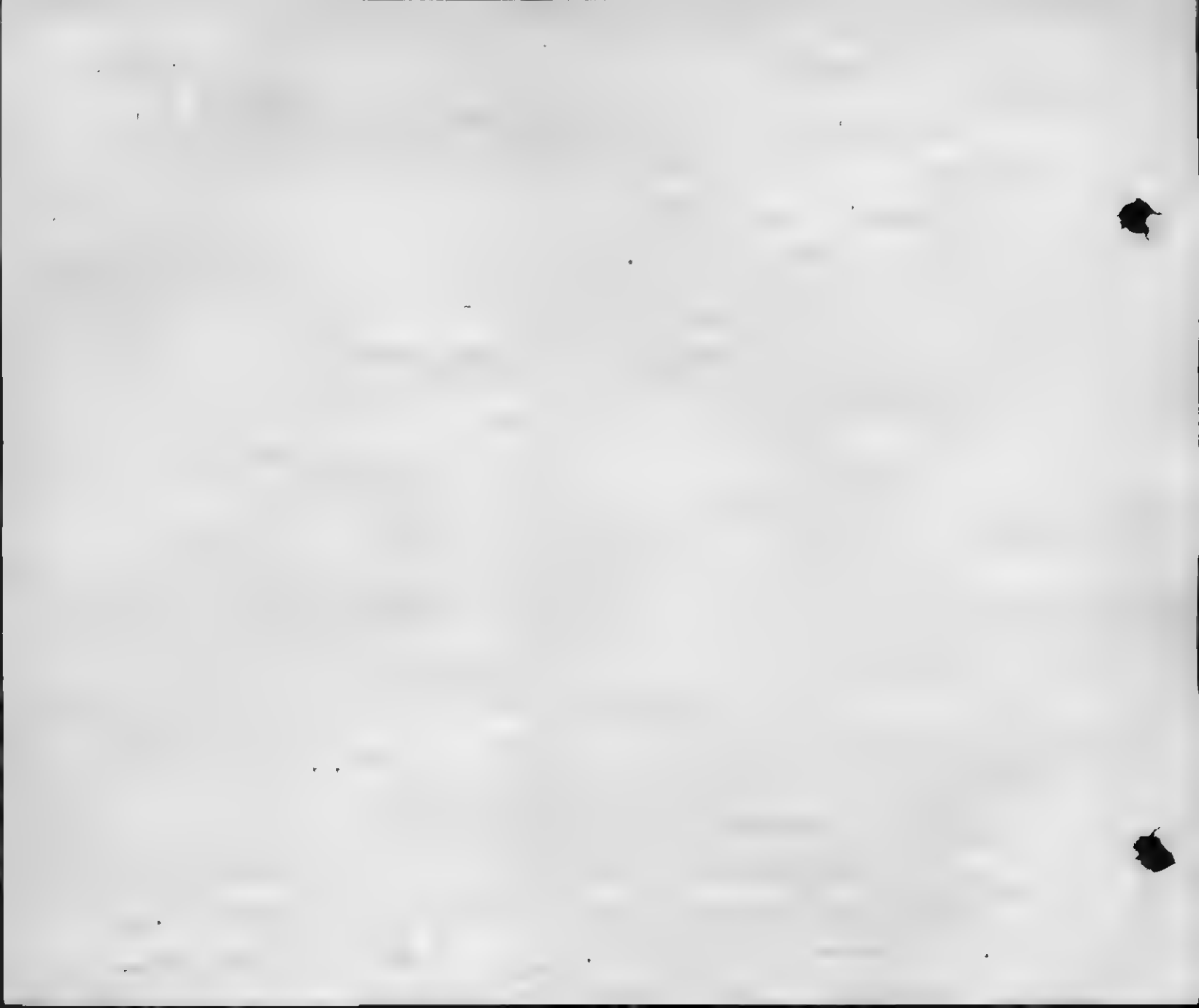
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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
10602													
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 Hour</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Colmar Manor</b> d. STREET ADDRESS <b>3601 - 39th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Ethel M. Slaughter</b>				4. DATE OF DEATH Month <b>September</b> Day <b>25</b> Year <b>1961</b>				5. SEX <b>Female</b>					
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-25-98</b>		9. AGE (in years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months <b>62</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Rutherford</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>Anna Slaughter Washington D C</b>	
17. INFORMANT <b>Anna Slaughter Washington D C</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral aneurysm, left carotid artery, dissecting</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Hypertension</b> (c) <b>Diabetes Mellitus - hyperosmolar</b>				INTERVAL BETWEEN ONSET AND DEATH <b>9/25/61</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>9</b> p.m. <b>25</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Colmar Manor</b>		20g. (County) <b>Prince George's</b>		20h. (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>9/25</b> to <b>9/25</b> , 1961, that (I) (we) last saw the deceased alive on <b>9/25</b> , 1961, and that death occurred at <b>2:30 p.m.</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>George Hageage</b>				22b. DATE SIGNED <b>9/26/61</b>				22c. PHYSICIAN'S NAME (Type) <b>George Hageage</b>				22d. ADDRESS <b>3717-38th Cottage City Rd</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Sept 28, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City, town or county) <b>Colmar Manor, Md.</b>		23e. REC'D BY REGISTRAR <b>SEP 29 '61</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				24a. ADDRESS <b>Hyattsville Md.</b>				24b. DATE <b>SEP 29 '61</b>				24c. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10603

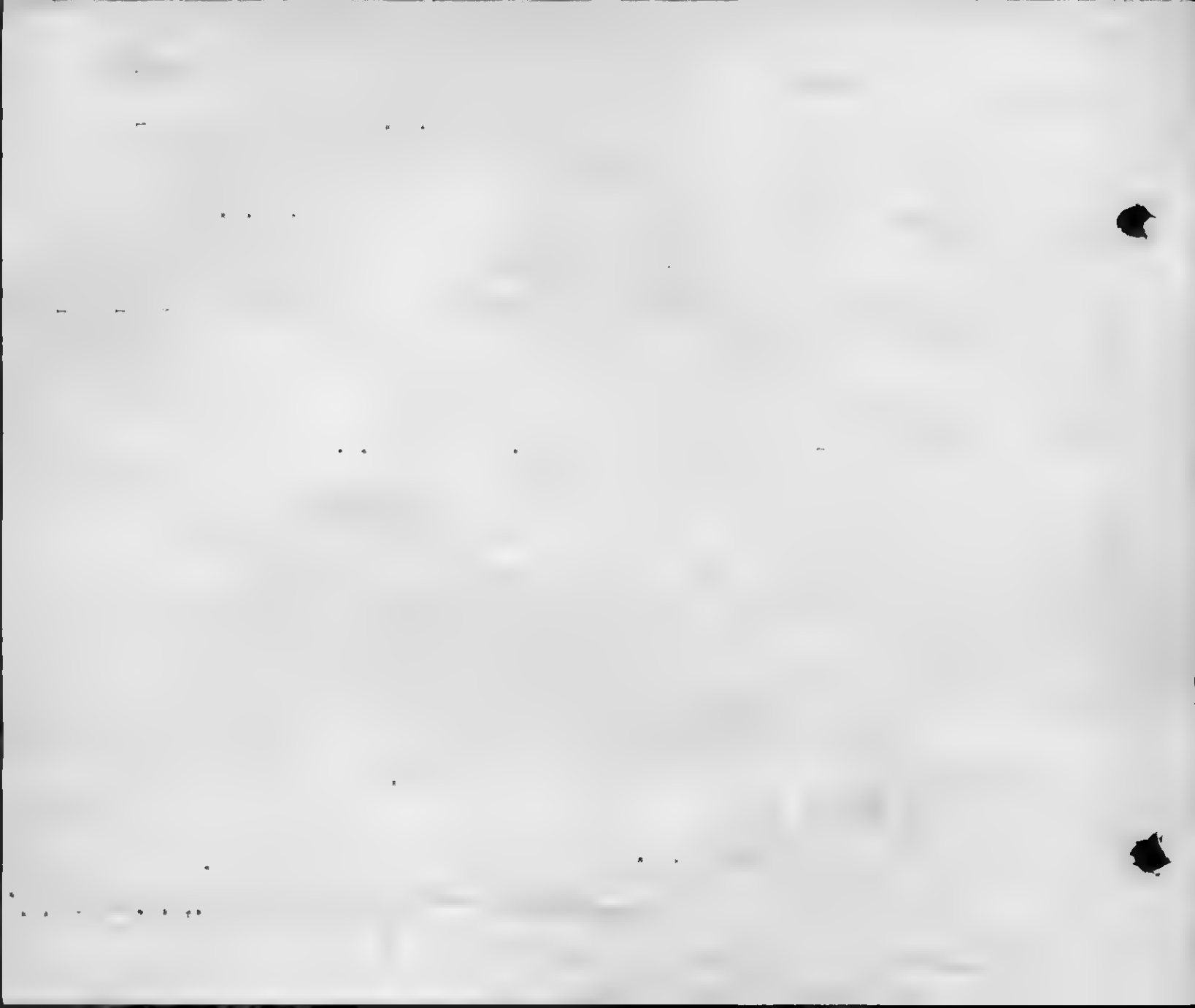
10610

<b>1. PLACE OF DEATH</b> a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE D. C. b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1231 Tee St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Glenn Sloan		<b>4. DATE OF DEATH</b> Month Day Year 9 5 19 61	
<b>5. SEX</b> Male <b>6. COLOR OR RACE</b> Negro <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> 9/2/1890 <b>9. AGE (In years last birthday)</b> 71 yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Unknown <b>10b. KIND OF BUSINESS OR INDUSTRY</b> Unknown		<b>11. BIRTHPLACE</b> (County & State, or foreign country) Unknown <b>12. CITIZEN OF WHAT COUNTRY?</b> Unknown	
<b>13. FATHER'S NAME</b> Unknown		<b>14. MOTHER'S MAIDEN NAME</b> Unknown	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) Unknown		<b>16. SOCIAL SECURITY NO</b> Unknown <b>17. INFORMANT</b> Mrs. Wiggley D.C. General Hospital, Md. GW Service	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma, right lung (b) 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (c) DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> 8/28 1961 <b>to</b> 9/5 1961, <b>that (I) (we) last saw the deceased alive on</b> 9/5 1961, <b>and that death occurred at</b> P.M. <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> Moe Weiss		<b>22b. DATE SIGNED</b> 9/5/61	
<b>22c. PHYSICIAN'S NAME (Type)</b> Moe Weiss, M. D.		<b>22d. ADDRESS</b> Glenn Dale Hospital Glenn Dale, Md.	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> 9-12-61		<b>23b. DATE THEREOF</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> Woodlawn Cemetery		<b>23d. LOCATION (City, town or county)</b> 4611 Benning Rd., S.E. Wash. D.C.	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> Malvan - Schey Inc 4249 St NW		<b>25a. REC'D BY REGISTRAR</b> SEP 11 '61	
<b>25b. REGISTRAR'S SIGNATURE</b> Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed with the State Department of Health. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was in the hospital, the certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

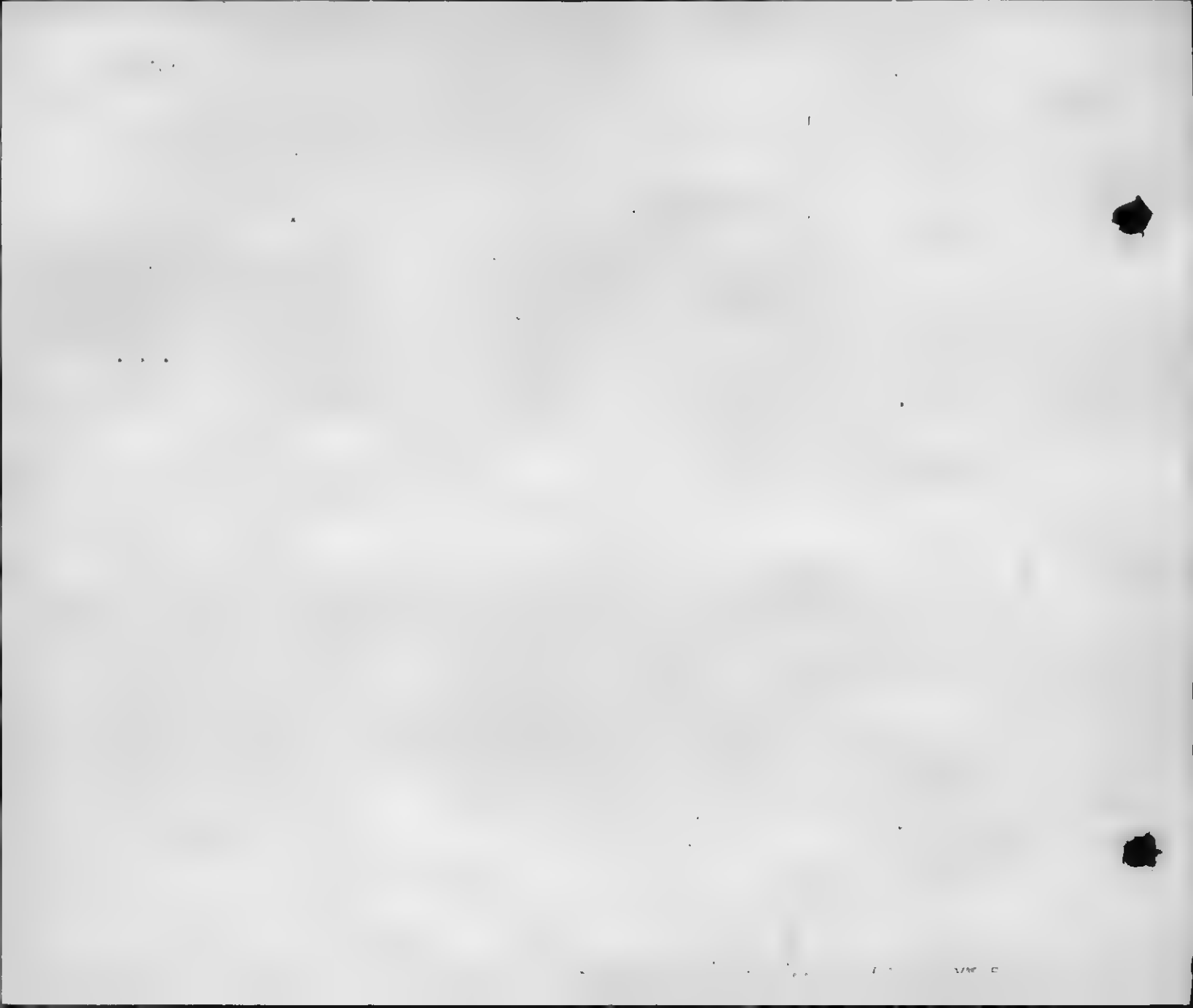
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10604

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		e. STREET ADDRESS <b>4013 Calvert Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy</b>	4. DATE OF DEATH Month <b>September</b> Day <b>12</b> Year <b>1961</b>	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/12/61</b>
9. AGE (In years) (If under 1 year, last birthday) <b>1</b> Months <b>54</b> Days <b>1</b> Hours <b>54</b> Mins.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
12. FATHER'S NAME <b>Bryan M. Slunt</b>		13. MOTHER'S MAIDEN NAME <b>Cheryl Lee Weaver</b>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		15. SOCIAL SECURITY NO. 17 INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>hydrocephalous, marked, congenital</b> 752X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20b. INJURY OCCURRED While at work Not While at work	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20d. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9/12/61</b> to <b>9/12/61</b> , that (I) (we) last saw the deceased alive on <b>9/12/61</b> , and that death occurred <b>4:50 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Herbert J. Friedel</b>		22b. DATE SIGNED <b>9/15/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>HERBERT J. FRIEDEL</b>		22d. ADDRESS <b>6826 RIGGS RD, HYATTSVILLE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<b>Cremation</b>	<b>9-18-61</b>	<b>Prince Geo. Gen. Hospital</b>	<b>Cheverly, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr., Administrator</b>		25a. REC'D BY REGISTRAR <b>SEP 21 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
10612																			
10605																			
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>187D Box 3303</b>														
3. NAME OF DECEASED (Type or print) <b>Baby Boy</b>					4. DATE OF DEATH Month <b>September</b> Day <b>11</b> Year <b>1961</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
5. SEX <b>Male</b>					6. COLOR OR RACE <b>Colored</b>					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> K									
8. DATE OF BIRTH <b>September 11, 1961</b>					9. AGE (in years; if UNDER 1 YEAR, last birthday) Months <b>8</b> Days <b>32</b>					10. USAL OCCUPATION (Give kind of work done during most of working life, even if retired)									
11. PLACE (County & State, or foreign country) <b>Prince Georges Co., Md.</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					13. FATHER'S NAME <b>Leroy M. Smith</b>									
14. MOTHER'S MAIDEN NAME <b>Shirley Ann</b>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO									
17. INFORMANT <b>Address</b>					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO <b>Atlectasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH									
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)					20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work Not While at work					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>9/11</b> to <b>9/11</b> , 1961, that (I) (we) last saw the deceased alive on <b>9/11</b> , 1961, and that death occurred at <b>9:20</b> , from the causes and on the date stated above.										22a. SIGNATURE <b>Dr. John W. Perkins</b>					22b. DATE SIGNED <b>F.M.</b>				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS <b>5301 Hamilton St., Hyattsville, Md.</b>					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF <b>9-16-61</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hospital</b>									
23d. LOCATION (City, town or county) (State)					23e. REC'D BY REGISTRAR <b>Cheverly, Md.</b>					23f. REGISTRAR'S SIGNATURE <b>SEP 19 '61</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>					24a. ADDRESS <b>5301 Hamilton St., Hyattsville, Md.</b>					24b. REGISTRAR'S SIGNATURE <b>Charles L. Hume</b>									



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence, hospital, or institution) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill	
c. LENGTH OF STAY IN 1b 60 yrs.		d. STREET ADDRESS 5360-Oxon Hill Rd 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Blanche Maryette Smith		4. DATE OF DEATH Sept. 23 1961	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-23-1893
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Bellevue Area, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Williams		14. MOTHER'S MAIDEN NAME Harriet Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 577460503	
17. INFORMANT Thelma Tanner Barnabas Rd.		Address 6250-St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621 Bronchiogenic Carcinoma (left lung) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH about 6 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1, 1961, to Sept. 23, 1961, that I last saw the deceased alive on Sept. 21, 1961, and that death occurred at 11:05 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Kenneth G. Brown		ADDRESS (Street, city or town, state) 3560-13th St. N.W. Wash. D.C.	
PHYSICIAN'S NAME (Type) Kenneth G. Brown-3560-13th St. N.W.		DATE SIGNED 9-24-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-27-61	22c. NAME OF CEMETERY OR CREMATORY St. Paul Methodist Church Cem.	22d. LOCATION (City, town, or county) (State) Oxon Hill, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Twining		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur S. Francis	DATE SEP 27 '61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

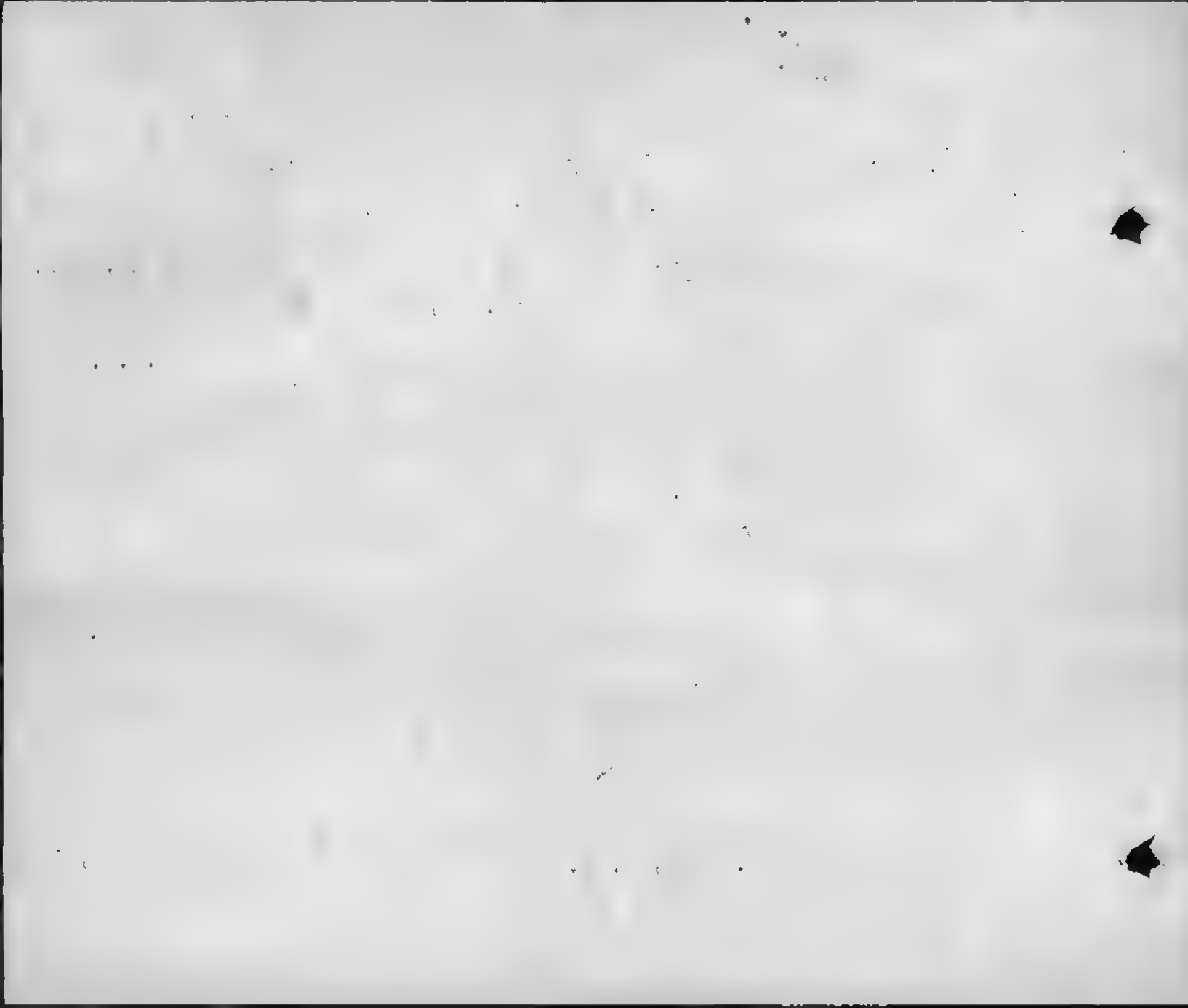
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Wm. J. Brown

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10615

## CERTIFICATE OF DEATH

Reg. Dist. No.

10808

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN 1b <b>Laurel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		d. STREET ADDRESS <b>507 Gorman Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>Kathryn Stanton</b>		4. DATE OF DEATH Month Day Year <b>September 17 19 61</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 19, 1916</b>		9. AGE (In years last birthday) <b>45 Yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Darsey Keys</b>		14. MOTHER'S MAIDEN NAME <b>Elmira Mae Baubitz</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Hospital Records</b>		17. INFORMANT <b>Hospital Records</b>		18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Guberochneoid Hemorrhage</b> DUE TO <b>Congenital Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>None</b> DUE TO (c) <b>None</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Hour o. m. p. m. 19 <b>8/17 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Laurel, Md.</b>		20g. (County) <b>Prince George</b>		20h. (State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>8/17 1961</b> to <b>9/17 1961</b> , that I last saw the deceased alive on <b>9/17 1961</b> , and that death occurred at <b>10:15 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>307 Prince George Street, Laurel, Md.</b>		DATE SIGNED <b>9/18/61</b>		ACTUAL SIGNATURE <b>John M. Warren</b>		PHYSICIAN'S NAME (Type) <b>John M. Warren, M.D. 307 Prince George Street, Laurel, Maryland</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/20/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Laurel, Md.</b>		22e. (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>DeWitt Donaldson</b>		ADDRESS <b>Laurel, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 26 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Thomas</b>		24c. (City or town) <b>Laurel, Md.</b>		24d. (County) <b>Prince George</b>		24e. (State) <b>Md.</b>		24f. (City or town) <b>Laurel, Md.</b>		24g. (County) <b>Prince George</b>		24h. (State) <b>Md.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**10616 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH  
a. COUNTY **Prince George's** **MARYLAND**  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Clinton**  
c. LENGTH OF STAY IN TB **Transient**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Rear of Hyde Field in Gravel Pit**

2. USUAL RESIDENCE (Where deceased lived, if institution, so designated)  
a. STATE **Md.** b. COUNTY **Montgomery**  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Silver Spring**  
d. STREET ADDRESS **Rt 2**

3. NAME OF DECEASED (Type or print)  
First **Wallace** Middle **Franklin** Last **Stephens**

4. DATE OF DEATH  
Month **September** Day **19** Year **1961**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH  
Month **Nov** Day **3** Year **1942**

9. AGE (in years last birthday) **18** yrs. 10. IF UNDER 1 YEAR Months **10** Days **10** 11. IF UNDER 24 HRS. Hours **10** Min. **10**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Laborer** 10b. KIND OF BUSINESS OR INDUSTRY **Contractor** 11. BIRTHPLACE (State or foreign country) **Md.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Charles C Stephens** 14. MOTHER'S MAIDEN NAME **ETTA Bridges**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **CHARLES C. Stephens** 17. INFORMANT **SAME** Address **- SAME**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Hemorrhage and shock**  
9/2.2 DUE TO **Crushed skull**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **Crushed skull**  
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) **Truck loaded with gravel turned over on him**

20c. TIME OF INJURY Month, Day, Year **9/19/61** 20d. INJURY OCCURRED While ☒ Not While ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Gravel pit** 20f. (City or town) **Clinton P.G.** (County) **Md**

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

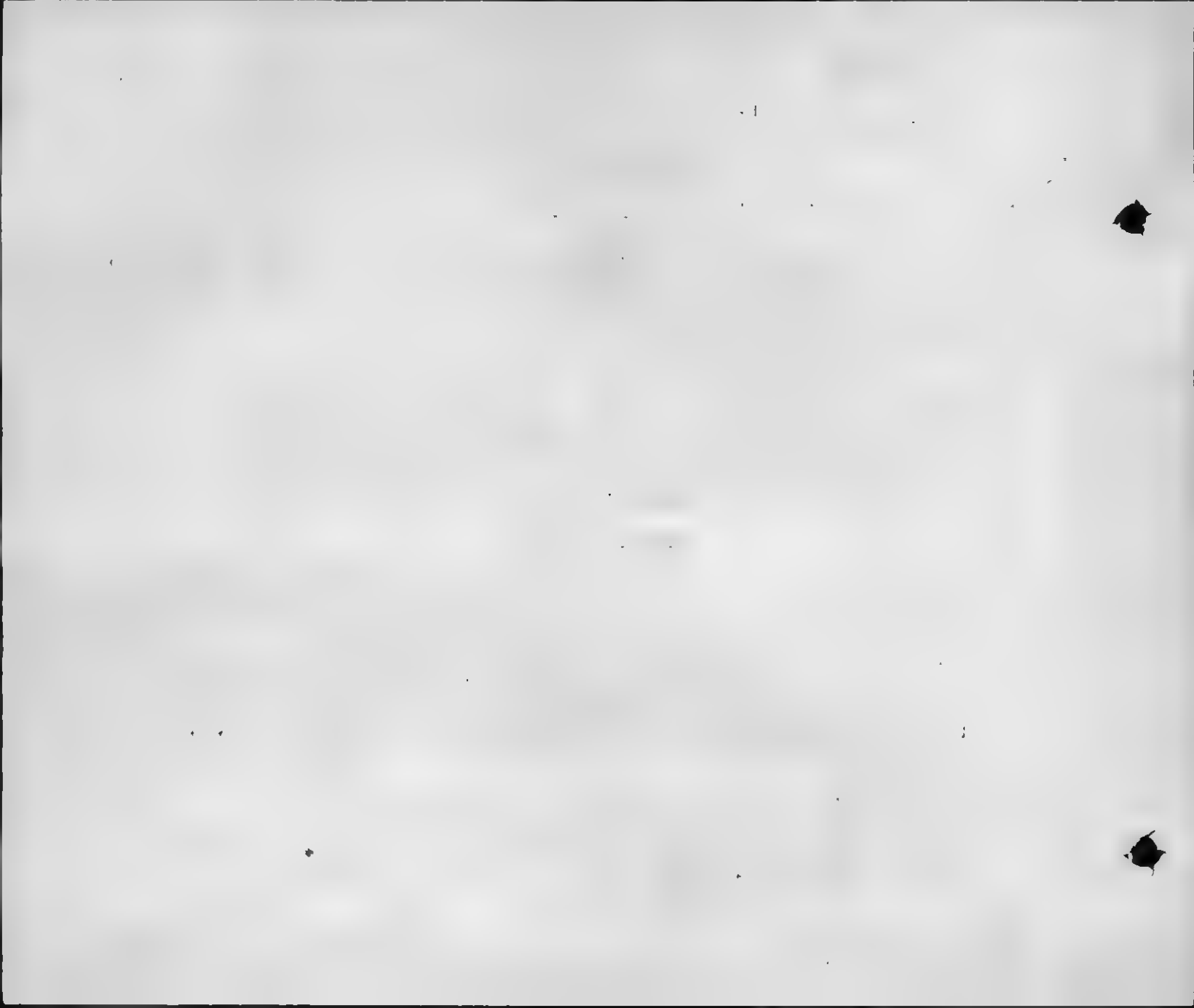
ACTUAL SIGNATURE **James I. Boyd** CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED **9/19/61**

EXAMINER'S NAME (Type) **James I. Boyd** Address (Street, city, town, or county) **King George Co. VA.**

22a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 22b. DATE THEREOF **Sept 22, 1961** 22c. NAME OF CEMETERY OR CREMATORY **Potomac Baptist Church Cemetery** 22d. LOCATION (City, town, or country) (State) **WASH. D.C.**

23. FUNERAL DIRECTOR **254 Carroll St. N.W.** 24a. FILED BY REGISTRAR **SEP 25 '61** 24b. REGISTRAR'S SIGNATURE **Arthur S. Kraw**

VS. A/ISME SM 9 60

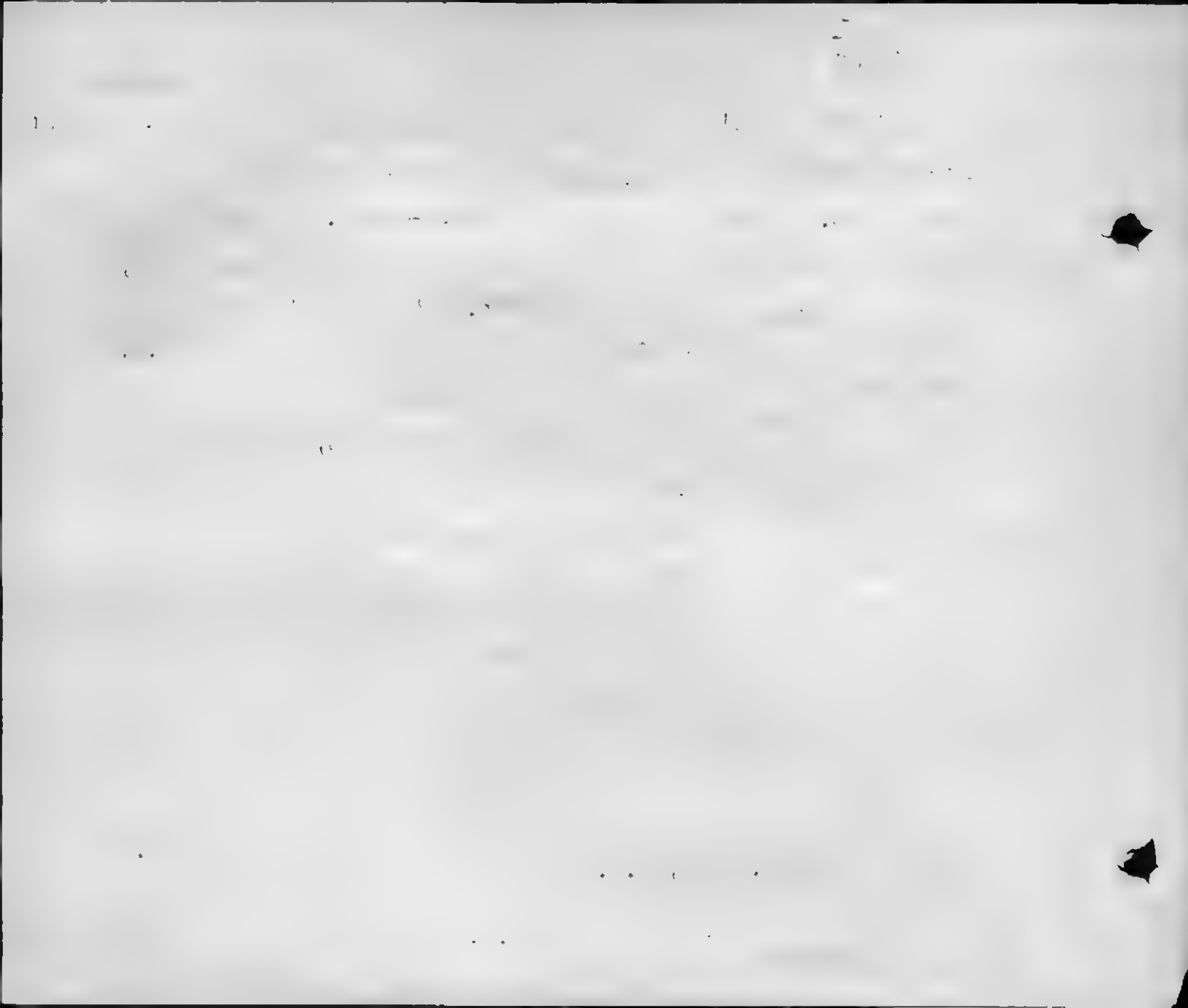


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																	
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
10617 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Brentwood</b>				c. LENGTH OF STAY IN TB <b>40 years</b>													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4508 - 41st. Avenue</b>																	
2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>																	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Brentwood</b>																	
d. STREET ADDRESS <b>4508 - 41st. Avenue</b>																	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <b>Georgianna Stockett</b>																	
4. DATE OF DEATH <b>September 27, 1961</b>																	
5. SEX <b>Female</b>																	
6. COLOR OR RACE <b>Colored</b>																	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>																	
8. DATE OF BIRTH <b>Dec. 18, 1883</b>																	
9. AGE (In years, If UNDER 1 YEAR, If UNDER 24 HRS. Birthdays) <b>77</b> yrs. Months Days Hours M.n.																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>					
13. FATHER'S NAME <b>Unknown</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of serv. ca.) <b>No</b>						16. SOCIAL SECURITY NO. <b>No</b>						17. INFORMANT <b>Lorretta Stockett, same as # 2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exhaustion</b> <b>51X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Carcinoma of the stomach</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Sept. 27, 1961</b> ACTUAL SIGNATURE <b>James I. Boyd</b> M.D. EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b> Address (Street, city, town, or county) 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>9.30.61</b> 22c. NAME OF CEMETERY OR CREMATORY <b>SHARP STREET CATHOLIC</b> 22d. LOCATION (City, Town, or county) (State) <b>SANDY SPRING, MARYLAND</b> 23. FUNERAL DIRECTOR <b>Robert L. McGuire</b> Address <b>1829 9TH ST., N.W. WASHINGTON, D.C.</b> 24a. REC'D BY REGISTRAR <b>SEP 29 '61</b> 24b. REGISTRAR'S SIGNATURE <b>C. H. S. Hanks</b>																	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10618

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 8295 9/25/61

10611

4 1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH  
a. COUNTY Prince George's MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forestville  
c. LENGTH OF STAY IN 1b 3 years  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Forestville Nursing Home

3. NAME OF DECEASED (Type or print)  
First Middle Last  
James Burke Story

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH July 10, 1888 9. AGE (In years last birthday) 73

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter 10b. KIND OF BUSINESS OR INDUSTRY Retired 11. BIRTHPLACE (State or foreign country) Georgia

13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. 579-40-4072 17. INFORMANT Shirley in Georgia Address 7512 Sherwood Ave, Rm. 4, Upper Marlboro

2. USUAL RESIDENCE (Where deceased lived, if institution residence, before admission)  
a. STATE Maryland b. COUNTY Prince George's  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forestville  
d. STREET ADDRESS Marlboro Pike E.E. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

9. AGE (In years last birthday) 73 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Cerebrovascular accident  
DUE TO  
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Cardiovascular renal disease  
DUE TO (c) \_\_\_\_\_

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) \_\_\_\_\_

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) \_\_\_\_\_

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 9 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 20f. (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_

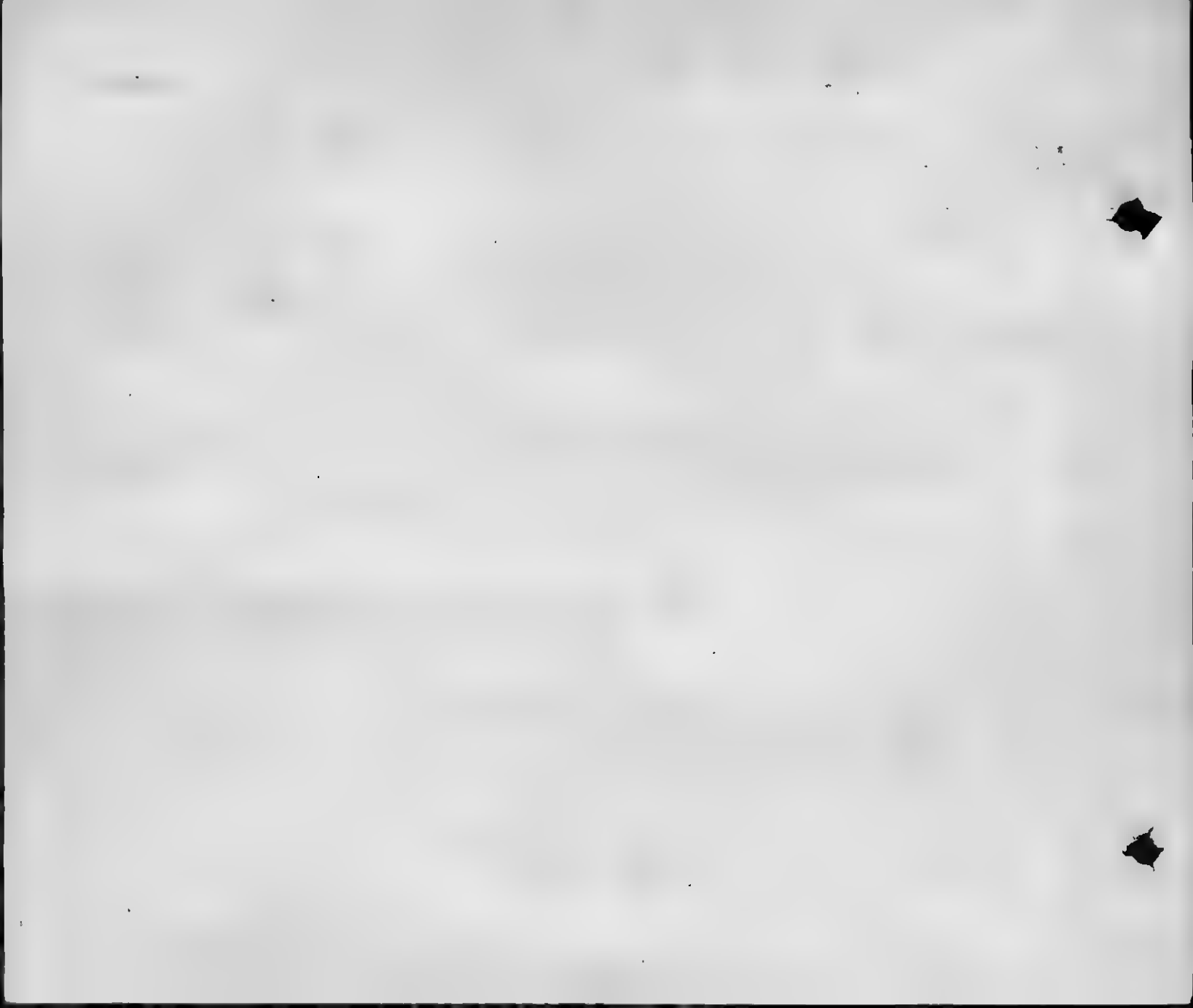
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE James I. Boyd M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 9/16/61

EXAMINER'S NAME (Type) JAMES I. BOYD Address (Street, city, town, or county) \_\_\_\_\_

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9/20/61 22c. NAME OF CEMETERY OR CREMATORY Arl. Nat'l. Cemetery 22d. LOCATION (City, town, or country) Arl. Va. (State) \_\_\_\_\_

23. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 5701 Cleveland Ave 24a. REC'D BY REGISTRAR SEP 19 '61 24b. REGISTRAR'S SIGNATURE Curtis S. Huns



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10619

## CERTIFICATE OF DEATH

Reg. Dist. No. 10612

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>WASHINGTON D.C.</u> b. COUNTY <u>4-1-X</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHILLUM</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>	
c. LENGTH OF STAY IN 1b <u>4 YRS.</u>		d. STREET ADDRESS <u>4444-YUMA ST. N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine A Sullivan</u>		4. DATE OF DEATH Month Day Year <u>9-8-1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-1875</u>
9. AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IRELAND.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL P. O'CONNOR.</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE HEALY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MAURICE O'CONNOR - 4444-YUMA ST NW.</u>	
17. INFORMANT Address <u>MAURICE O'CONNOR - 4444-YUMA ST NW.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis with Myocardial Infarction.</u> 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease.</u> 3 years DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/26/1958</u> , 19____, to <u>9/8/1961</u> , 19____, that I last saw the deceased alive on <u>9/7/1961</u> , 19____, and that death occurred at <u>11:35 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas F. Collins</u> M.D.		ADDRESS (Street, city or town, state) <u>322- H. St. N.E.</u> DATE SIGNED <u>9-8-1961</u>	
PHYSICIAN'S NAME (Type) <u>Thomas F. Collins, M.D.</u>		<u>Washington 2, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-11-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Winifred Naylor - 3851 GA. AVENUE</u>		24. REC'D BY REGISTRAR ADDRESS <u>SEP 14 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Winifred Naylor</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

<div>1</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div>									
<div>10620</div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Prince George's</div> <div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Cheverly</div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>Prince George's General</div> </div>					<div> <div>10613</div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> <div>Maryland</div> <div>b. COUNTY</div> <div>Prince George's</div> <div>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Bladensburg</div> <div>d. STREET ADDRESS</div> <div>4107 51st Avenue</div> </div>				
<div>3. NAME OF DECEASED (Type or print)</div> <div>Charles Szenas</div>					<div>4. DATE OF DEATH</div> <div>September 30 1961</div>				
<div>5. SEX</div> <div>Male</div>					<div>6. COLOR OR RACE</div> <div>White</div>				
<div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>					<div>8. DATE OF BIRTH</div> <div>July 24, 1908</div>				
<div>9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Fountain Manager</div>					<div>9b. KIND OF BUSINESS OR INDUSTRY</div> <div>Peoples Drug Stores</div>				
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Fountain Manager</div>					<div>11. 8 RTMPLACE (State or foreign country)</div> <div>Hungary</div>				
<div>13. FATHER'S NAME</div> <div>Charles Szenas</div>					<div>14. MOTHER'S MAIDEN NAME</div> <div>Unknown</div>				
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</div> <div>Yes 1926 1926</div>					<div>16. SOCIAL SECURITY NO.</div> <div>Charlotte Szenas, same as #2</div>				
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) Subdural Hematoma</div> <div>903.5 DUE TO</div> <div>Conditions, if any, which gave rise to immediate cause (b) Fracture of the skull</div> <div>(a), stating the underlying cause last. DUE TO (c)</div>					<div>INTERVAL BETWEEN ONSET AND DEATH</div>				
<div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</div>									
<div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>									
<div>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div>					<div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>Fall in the street</div>				
<div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>9/29/ 19 61</div>					<div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/></div>				
<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>Street</div>					<div>20f. (City or town) (County) (State)</div> <div>Bladensburg P.G. Md</div>				
<div>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/></div>									
<div>ACTUAL SIGNATURE</div> <div>James I. Boyd, M.D.</div>					<div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></div>				
<div>EXAMINER'S NAME (Type)</div> <div>James I. Boyd, M.D.</div>					<div>DATE SIGNED</div>				
<div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>					<div>22b. DATE THEREOF</div> <div>Oct 4, 1961</div>				
<div>22c. NAME OF CEMETERY OR INTERMENT</div> <div>Arlington National</div>					<div>22d. LOCATION (City, town, or country) (State)</div> <div>Arlington Va</div>				
<div>23. FUNERAL DIRECTOR</div> <div>F. Gasch's Sons</div>					<div>24a. REC'D BY REGISTRAR</div> <div>Oct 4 '61</div>				
<div>ADDRESS</div> <div>Hyattsville Md.</div>					<div>24b. REGISTRAR'S SIGNATURE</div> <div>William L. Thomas</div>				



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

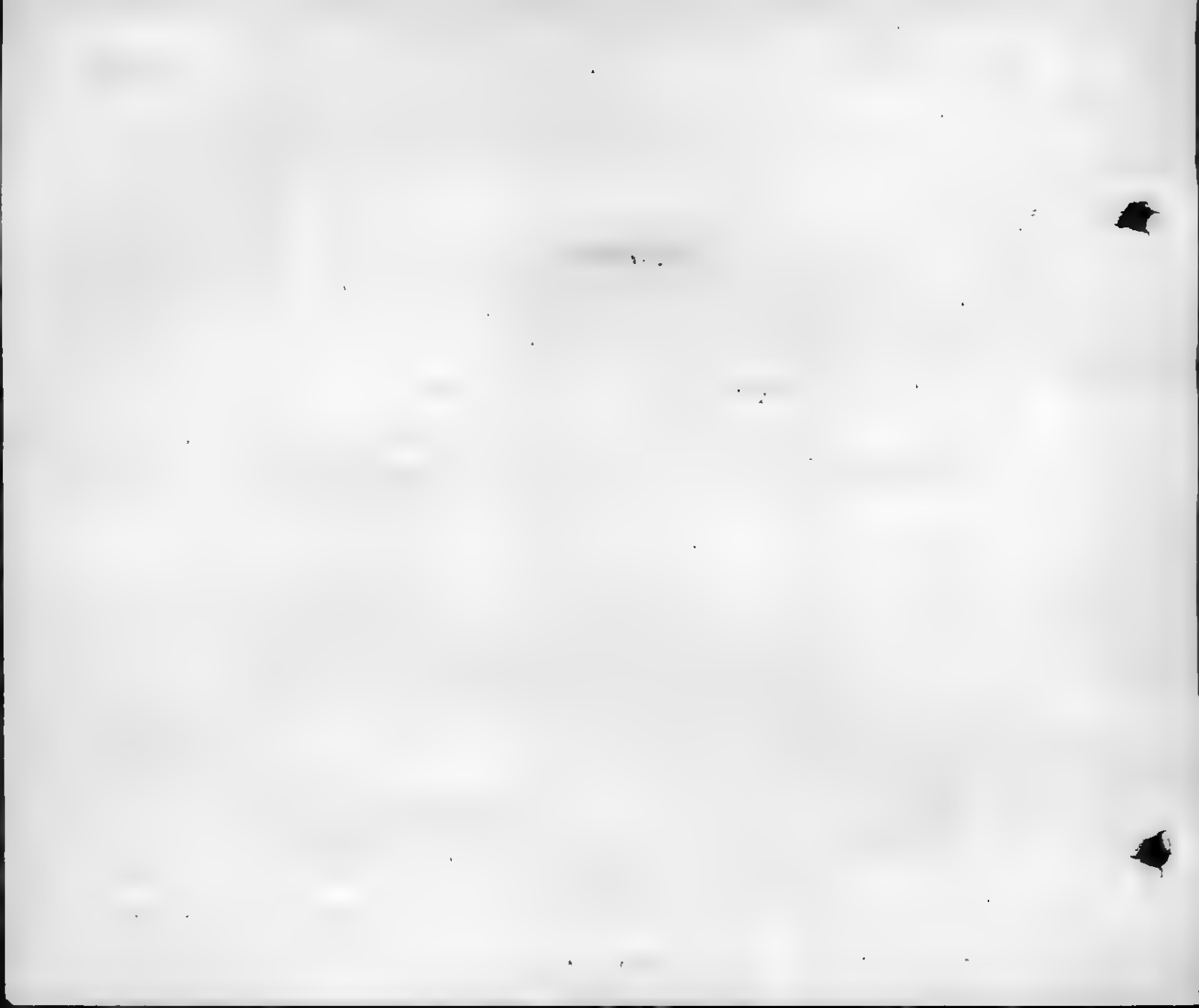
(M)

10621

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10614

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Bowie</i>			
b. CITY OR TOWN (If outside corporate limits, give RURAL and give nearest town) <i>Hyattsville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bowie Md</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>MADISON MANOR</i>				d. STREET ADDRESS <i>P.O. Box 194</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Henry</i> Middle <i>E.</i> Last <i>Thornberry</i>				4. DATE OF DEATH Month <i>Sept</i> Day <i>9</i> Year <i>1961</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 7, 1895</i>	
9. AGE in years (last birthday) <i>66</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired car inspector</i>		11. BIRTHPLACE (State or foreign country) <i>Washington D C</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Edward E Thornberry</i>				14. MOTHER'S MAIDEN NAME <i>Amanda -</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT Address <i>Nellie C Thornberry Bowie, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>							<i>3 mo.</i>
DUE TO (b) <i>Arterial Hypertension</i>							<i>5 mo.</i>
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <i>8/30</i> 19 <i>61</i> to <i>9/9</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>9/8</i> 19 <i>61</i> , and that death occurred at <i>5:30 AM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Harold F. McCann</i> M.D.				22b. ADDRESS <i>3355 - 16th St. N.W. Wash. D.C.</i>		22c. DATE SIGNED <i>9/9/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>HAROLD F. MCCANN</i>				22d. ADDRESS <i>3355 - 16th St. N.W. Wash. D.C.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept 12, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Church of Ascension Cemetery</i>		23d. LOCATION (City, town, or county) <i>Bowie, Md.</i> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i> ADDRESS <i>Hyattsville, Md.</i>				25a. REC'D BY REGISTRAR <i>SEP 14 '61</i> DATE		25b. REGISTRAR'S SIGNATURE <i>S. Thomas</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

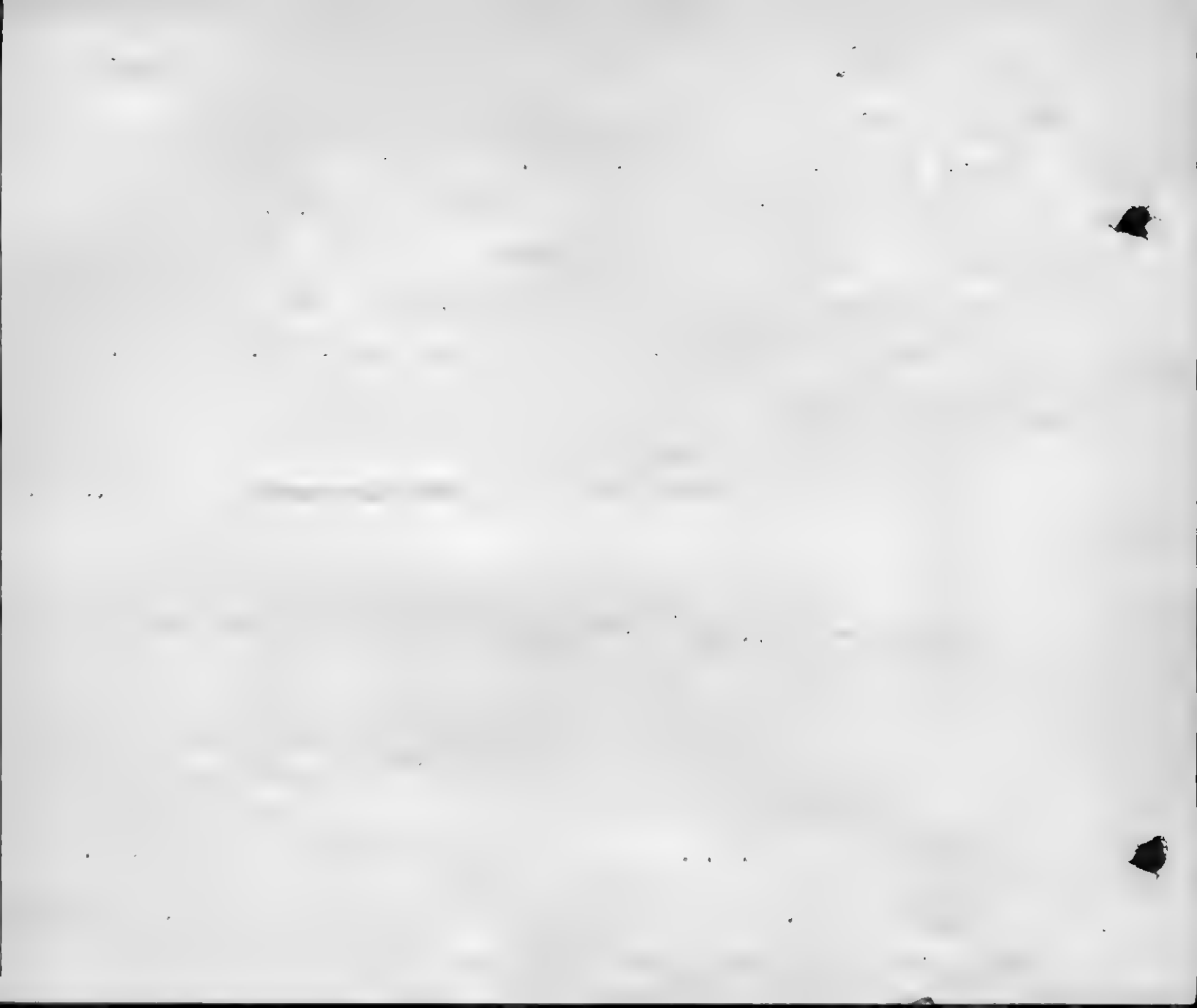
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15M 9/60

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10622

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10615

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Glenn Dale c. LENGTH OF STAY IN 1b 1 year, 28 das. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY District of Columbia c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1225 L Street, N. W.	
3. NAME OF DECEASED (Type or print) Ida A. Thornton First Middle Last		4. DATE OF DEATH Sept. 17 1961 Month Day Year	
5. SEX Female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 16, 1871 9. AGE (In years last birthday) 90 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY - 11. BIRTHPLACE (County & State, or foreign country) Jefferson County, Tenn. 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harrison Rainwater 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. none 17. INFORMANT Elizabeth Lewis Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Generalized Arteriosclerosis; fracture of right humerus and right femur 8/61; open reduction, right femur fracture, 8/61 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 yr., 1 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/19/60 2:40 to 9/17/61 19....., that (I) (we) last saw the deceased alive on 9/17/61 19....., and that death occurred at A.M., from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22b. DATE SIGNED 9/17/61 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF SEPT. 21/61 23c. NAME OF CEMETERY OR CREMATORY CHESTNUT HILLS 23d. LOCATION (City, town or county) (State) CHESTNUT HILLS, TENNESSEE			
24. FUNERAL DIRECTOR'S SIGNATURE Hysong's Funeral Home ADDRESS WASH. D.C. DATE SEP 19 '61		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Arthur L. House	

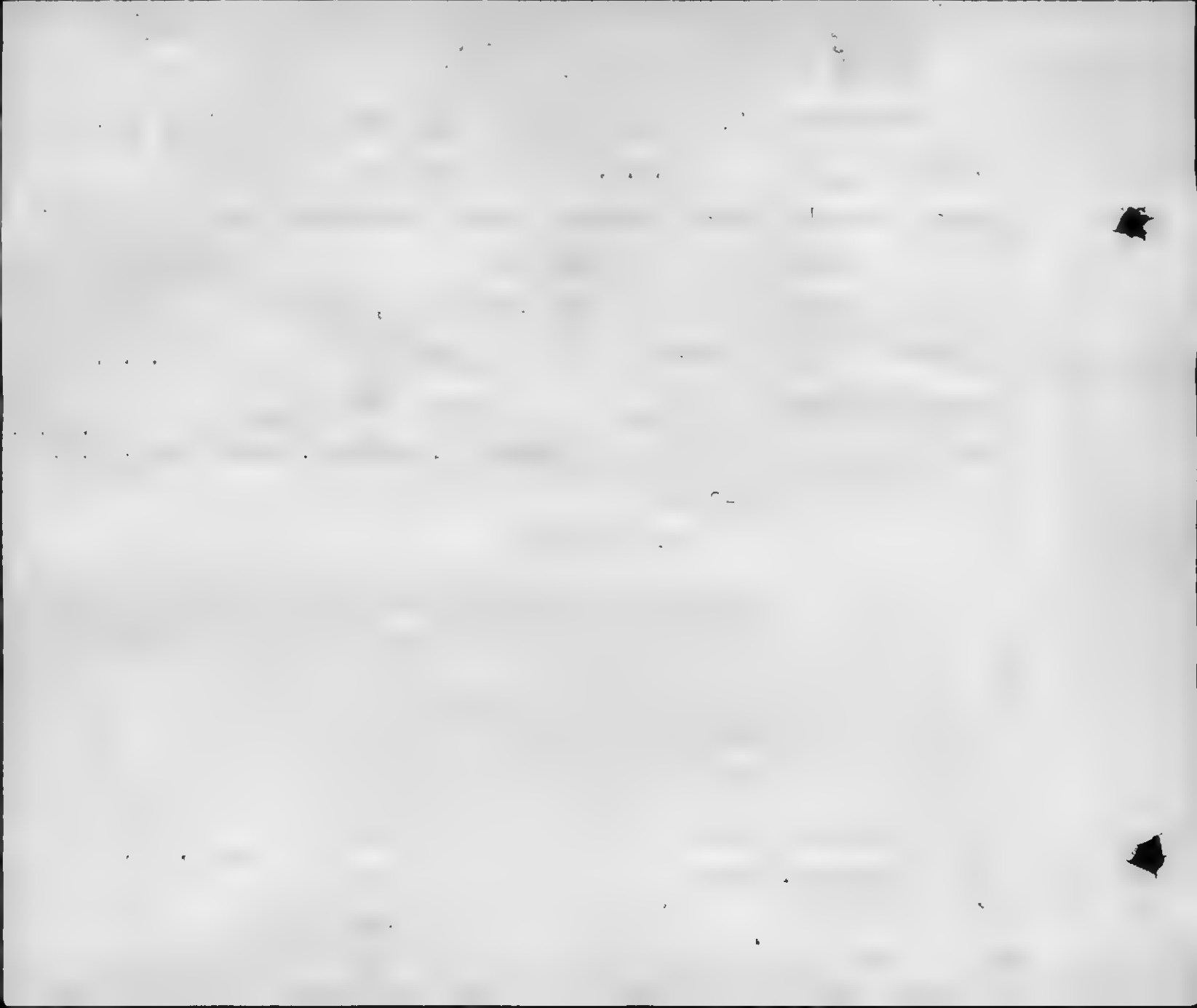


1  
FOR STATE  
HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10623  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND  
10616  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if not last one; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		e. STREET ADDRESS <b>18271 Livingston Road</b>	
3. NAME OF DECEASED (Type or print) <b>LeRoy Vanderbeck</b>		4. DATE OF DEATH <b>September 27 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>January 17, 1899</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred Vanderbeck</b>		14. MOTHER'S MAIDEN NAME <b>Alice Wright</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>232 Portland St. S.E.</b>	
17. INFORMANT <b>Dorothy L. Sprinkle Washington, D.C.</b>		18. INTERVAL BETWEEN ONSET AND DEATH	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia</b> DUE TO (b) <b>Lobar Pneumonia</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		DATE SIGNED <b>Sept. 27, 1961</b>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-29-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oxon Hill</b>		22d. LOCATION (City, town, or country) (State) <b>Switzerland Md</b>	
23. FUNERAL DIRECTOR <b>Sumner Bros.</b>		24a. REC'D BY REGISTRAR <b>SEP 29 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>		24c. ADDRESS (Street, city, town, or county) <b>1661 - Wood Hope Rd SE Wash D.C.</b>	



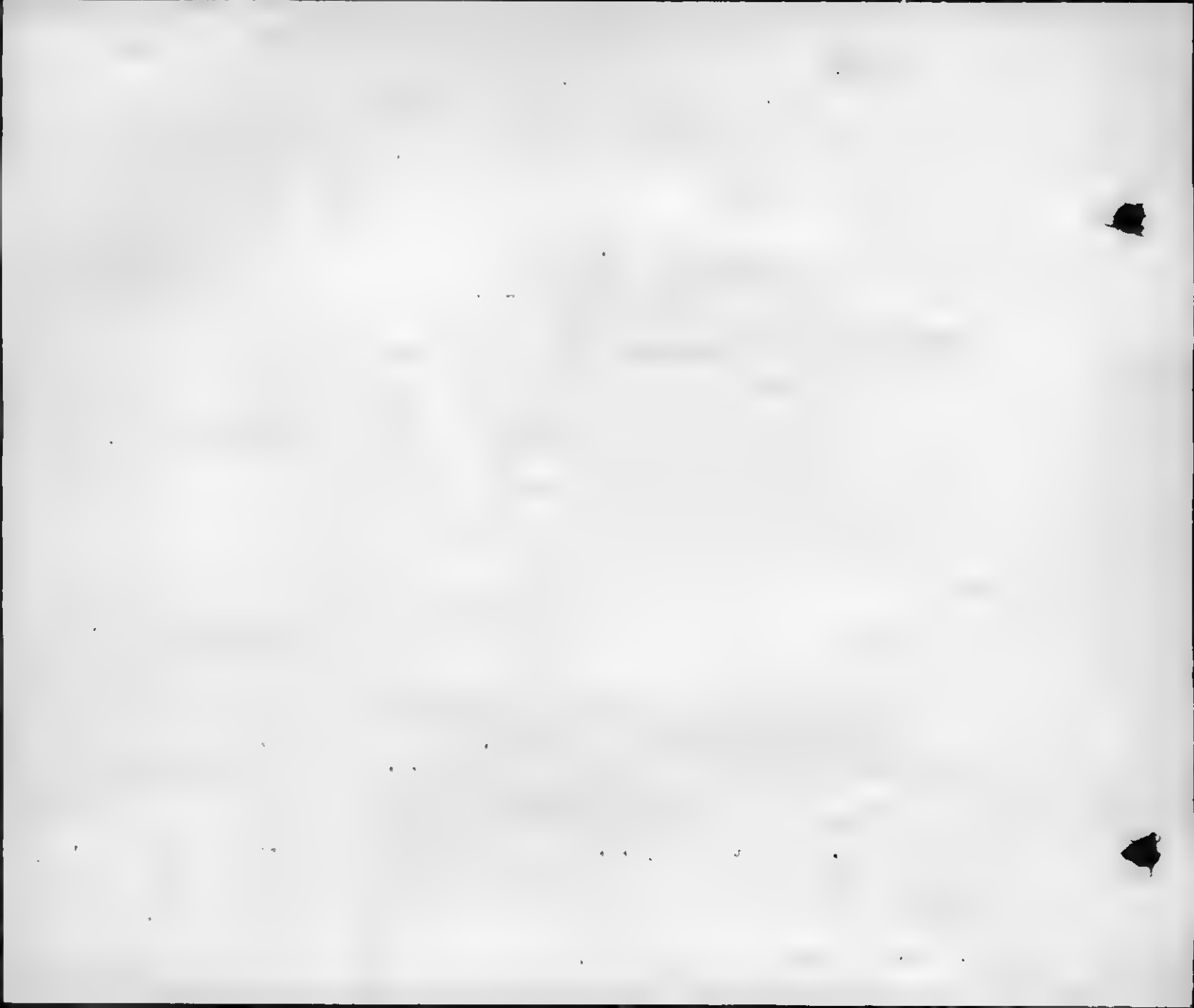
may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10624

10617

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leonard Middle F. Last Vass		4. DATE OF DEATH Month September Day 3 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-10-1894
9. AGE (In years last birthday) yrs 67		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME Issac Vass		14. MOTHER'S MAIDEN NAME ? Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17 INFORMANT Leonard E Vass		Address Berwyn Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Coronary Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Fractured hip INTERVAL BETWEEN ONSET AND DEATH hours years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1 19 61 to Sept. 3 19 61, that (I) (we) last saw the deceased alive on Sept. 3 19 61 and that death occurred at 7:05 P.M., from the causes and on the date stated above.			
22a. SIGNATURE Dr. Samuel S. Sugar, M.D.		22b. DATE / SIGNATURE 9/4/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 5801 Baltimore Ave., Hyattsville, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 6, 1961	
23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		23d. LOCATION (City, town, or county) (State) Hyattsville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE SEP 8 '61	
ADDRESS Hyattsville Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10625

10618

### 1. PLACE OF DEATH

a. COUNTY

PRINCE GEORGE'S MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BRANDYVINE

c. LENGTH OF STAY IN

32 YRS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Rt 3 Box 257 A

### 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

MARYLAND

b. COUNTY

PRINCE GEORGE'S

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BRANDYVINE

d. STREET ADDRESS

Rt 3 Box 257 A

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

### 3. NAME OF

(Type or print)

THEODORE FRANCIS WARTFEMIL

### 4. DATE OF DEATH

Month

SEPT

Day

5

Year

1961

### 5. SEX

M

### 6. COLOR OR RACE

W

### 7. MARRIED

☐ NEVER MARRIED ☐

### 8. DATE OF BIRTH

JAN. 28, 1889

### 9. AGE (In years last birthday)

72 yrs

### 10. IF UNDER 1 YEAR

Months Days

### 11. IF UNDER 24 HRS.

Hours Min.

### 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CARPENTER

### 10b. KIND OF BUSINESS OR INDUSTRY

SELF-EMPLOYED

### 11. BIRTHPLACE (County & State or foreign country)

DELFT, HOLLAND

### 12. CITIZEN OF WHAT COUNTRY?

NETHERLANDS

### 13. FATHER'S NAME

THEODORE F. WARTFEMIL

### 14. MOTHER'S MAIDEN NAME

J. CHANNA LANGE

### 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

NO

### 16. SOCIAL SECURITY NO.

217-03-2346

### 17. INFORMANT

WIFE

### Address

Rt 3 Box 257 A BRANDYVINE

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

#### PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

+201 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

TERMINAL BRONCHOPNEUMONIA

CEREBRAL EMBOLUS - INTERMITTENT VENTRICULAR ARRHYTHMIA

ANTEIOSEPTAL-MYOCARDIAL INFARCTION 3 1/2 WEEKS

#### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

BENIGN PROSTATIC HYPERTROPHY WITH LEUKEMIA

### 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING TO CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

None

### 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

None

### 20c. TIME OF INJURY

Month, Day, Year

Hour, a.m., p.m.

None

### 20d. INJURY OCCURRED

While at work ☐ Not while at work ☒

### 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

None

### 20f. (City or town)

None

### (County)

None

### (State)

None

21. I certify that (I) (the undersigned) attended the deceased from ~~April 18, 1961~~ ~~April 18, 1961~~ that (I) (we) last saw the deceased alive on ~~April 15, 1961~~ ~~April 15, 1961~~ and that death occurred at ~~10 AM~~ ~~10 AM~~ from the causes and on the date stated above.

### 22a. SIGNATURE

Arthur Shaver Jr.

M.D.

### ATTENDING PHYS.

☒

### MED. DIRECTOR

☐

### STAFF PHYS.

☐

### 22b. DATE SIGNED

4/5/61

### 22c. PHYSICIAN'S NAME (Type)

ARTHUR SHAVER JR.

### 22d. ADDRESS

BRANCH AVE. - CLINTON, MD

### 23a. BURIAL, CREMATION, REMOVAL (Specify)

Cremation

### 23b. DATE THEREOF

9-8-61

### 23c. NAME OF CEMETERY OR CREMATORY

Fort Lincoln Crematory

### 23d. LOCATION (City, town or county)

Bladensburg

### (State)

MD

### 24. FUNERAL DIRECTOR'S SIGNATURE

Simmons Bros.

### ADDRESS

1661 - Good Hope Rd WASH. DC

### 25a. REC'D BY REGISTRAR

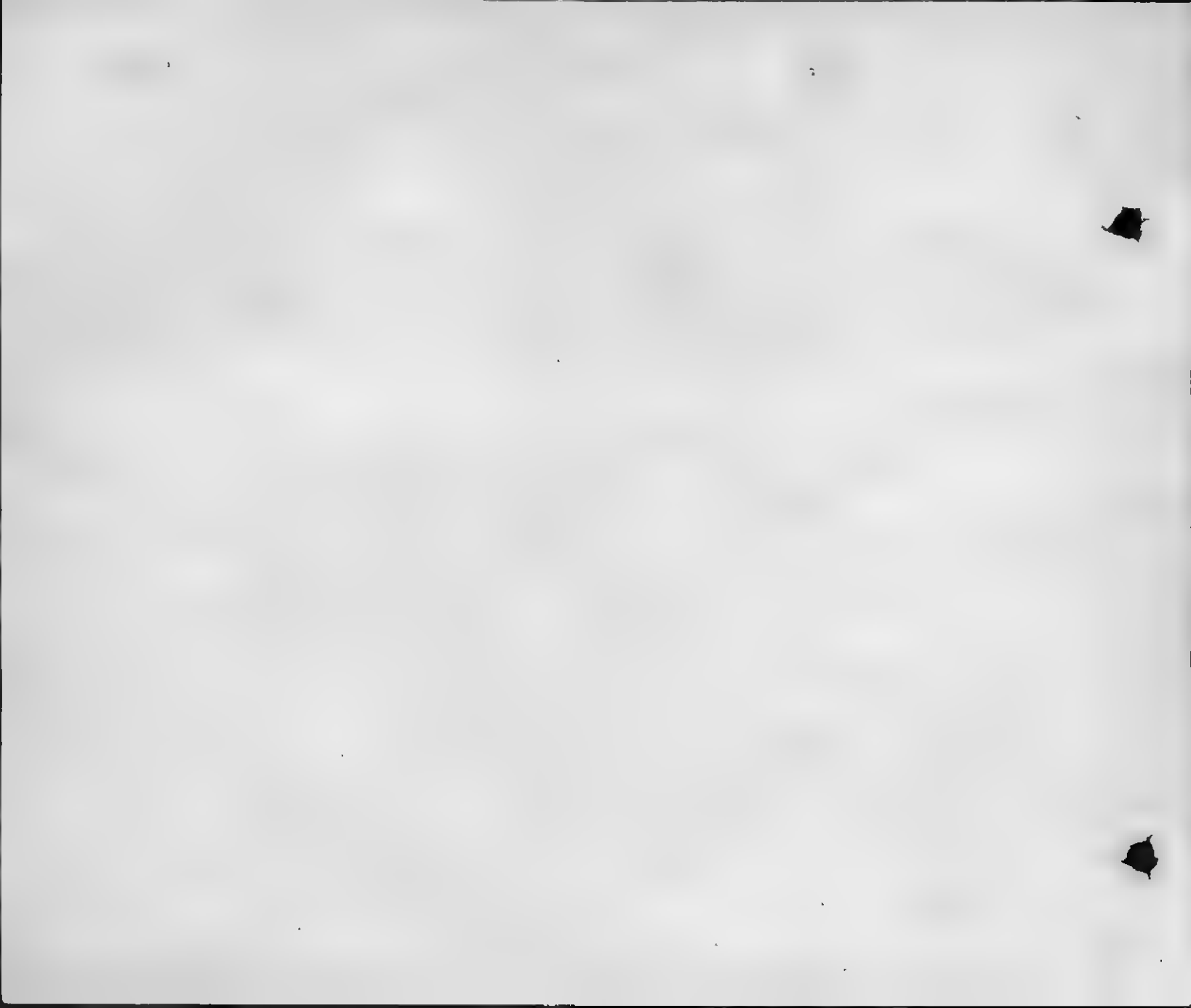
SEP 7 '61

### 25b. REGISTRAR'S SIGNATURE

Charles P. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completed and signed by the attending physician and completed and signed by the funeral director. After this certificate has been signed by the attending physician and completed and signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10626

## CERTIFICATE OF DEATH

10619

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RJRRL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b. <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RJRRL and give nearest town) <b>Brandywine</b> d. STREET ADDRESS <b>Rt. 2 Box 160</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Baby Boy</b> First Middle Last <b>Male</b> <b>Colored</b> 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>September 13, 1961</b> 9. AGE (in years last birthday) <b>1</b> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. <b>1</b>		<b>4. DATE OF DEATH</b> <b>September 14, 1961</b> Month Day Year 10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Prince Georges Co., Md.</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.A.</b> 11. K. PLACE County & State (or foreign country) 12. CITIZEN OF WHAT COUNTRY?	
<b>13. FATHER'S NAME</b> <b>Joseph Herbert Swann</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>Thelma Mae Washington</b> <b>17. INFORMANT</b> Address		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Atelutasis</b> <b>1b2's</b> DUE TO <b>Primaturity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19 <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from 9/13, 1961, to 9/14, 1961, that (I) (we) last saw the deceased alive on 9/14, 1961, and that death occurred at 1:10, from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <b>John P. Perkins</b> M.D. <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>22b. DATE SIGNED</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>cremation</b> <b>23b. DATE THEREOF</b> <b>9/21/61</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Prince George's Gen. Hosp</b> <b>23d. LOCATION (City, town or county)</b> <b>Cheverly, Maryland</b> <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Harry W. Penn, Jr. Administrator</b> <b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>SEP 25 '61</b> <b>Arthur S. Haines</b>	

VR A15 (4)  
15M 9/60

47



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10627

10620

FOR STATE  
HEALTH DEPT.

### 1. PLACE OF DEATH

a. COUNTY

*Pr Geo*

b. CITY OR TOWN (If outside of corporate limits write RURAL and give nearest town)

*Cheverly*

c. LENGTH OF STAY IN 1b

*Do A*

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

*Pr Geo General*

3. NAME OF DECEASED (Type or print)

*McVay*

First

Middle

*Aloysius*

*Washington*

Last

5. SEX

*M*

6. COLOR OR RACE

*Colored*

7. MARRIED

☒ NEVER MARRIED

WIDOWED

☐ DIVORCED

8. DATE OF BIRTH

*Sept 30, 1919*

9. AGE (In years last birthday)

*41*

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Clerk*

10b. KIND OF BUSINESS OR INDUSTRY

*U.S. Govt.*

11. BIRTHPLACE (State or foreign country)

*District of Columbia*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*OWEN J. Washington*

14. MOTHER'S MAIDEN NAME

*Lillie Washington*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a).

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

*Cerebral Lacerations & Contusions  
Fractured Skull - Swelling  
multiple wounds from bullet left*

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

*Subject hit by an automobile*

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

p.m.

*9/15/61*

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

*Dayton Watkins*

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S NAME (Type)

*DAYTON O WATKINS*

Address (Street, city, town, or county)

*9-16-61*

22a. BURIAL, CREMATION, REMOVAL (Specify)

*BURIAL*

22b. DATE THEREOF

*9.20.61*

22c. NAME OF CEMETERY OR CREMATORY

*MT. OLIVET CEMETERY*

22d. LOCATION (City, town, or country)

*WASHINGTON, D.C.*

23. FUNERAL DIRECTOR

*Robt. A. McLean*

24a. ADDRESS

*1420 14TH ST., N.W.*

24b. REC'D BY REGISTRAR

*SEP 19 '61*

24b. REGISTRAR'S SIGNATURE

*Arthur S. Brand*

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

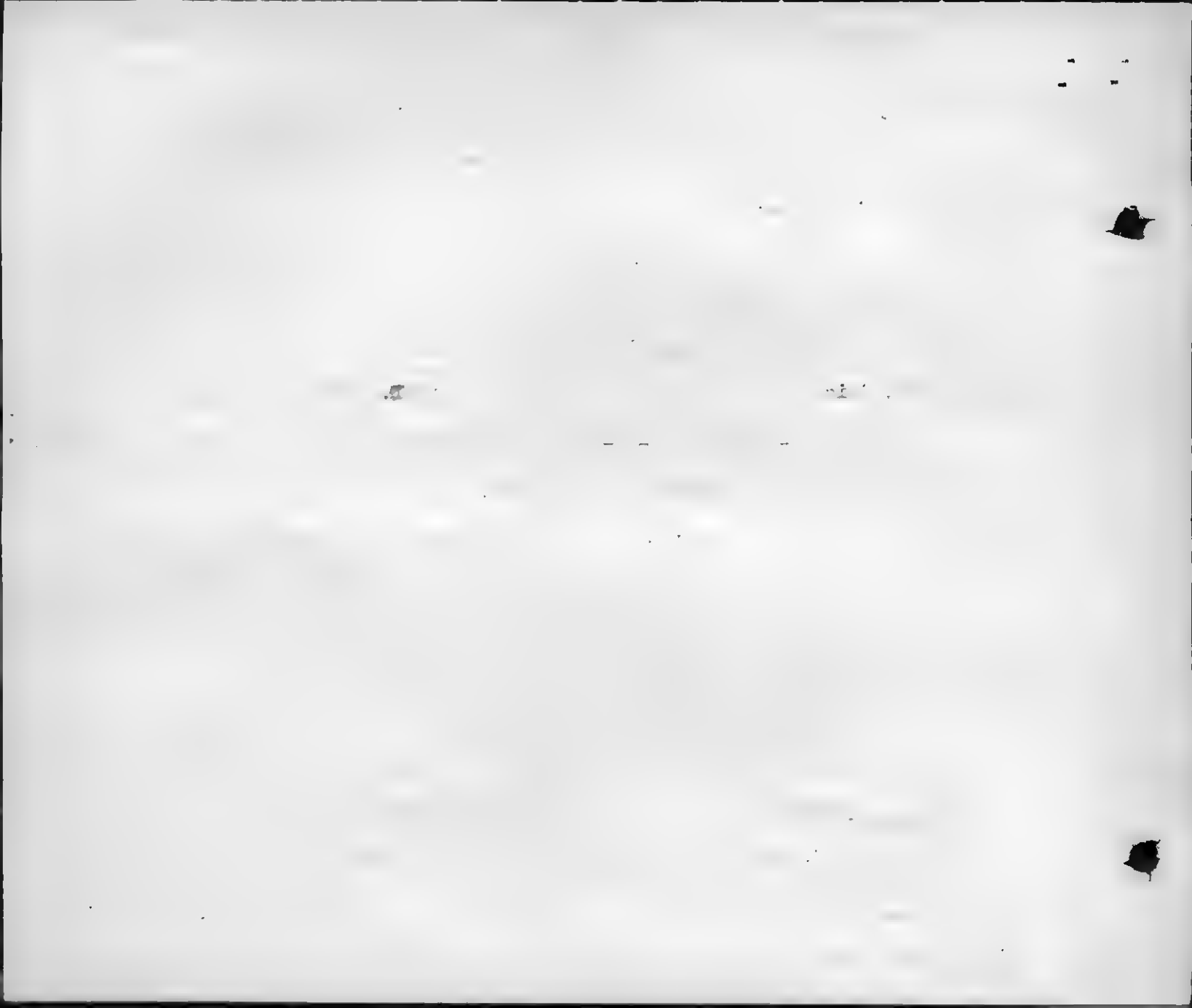
1  
10628

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10621

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital, Andrews AFB				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First MIDDLE LAST THELMA RUTH WATSON				4. DATE OF DEATH Month Day Year Sept 17 19 61			
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 March 1922		9. AGE (In years lost birthday) yrs 39	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BX Manager		10b. KIND OF BUSINESS OR INDUSTRY Merchandising		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME J. Edgar Quicksall				14 MOTHER'S MAIDEN NAME Dora M. Lovely			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWII (Jan-Jun 42) 234-28-4075		17 INFORMANT Husband		Address 18 McKay Road, Brandywine, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intestinal Obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of cervix, metastatic to peritoneum DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 years 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 15 Aug 61 to 17 Sep 1961, that (I) (we) last saw the deceased alive on 17 Sep 1961, and that death occurred at 0640 M, from the causes and on the date stated above							
22a. SIGNATURE Paul F. Griner				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 17 Sep 61	
22c. PHYSICIAN'S NAME (Type) PAUL F. GRINER, CAPT, USAF MC				22d. ADDRESS USAF Hospital, Andrews AFB, Wash 25, DC			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-20-61		23c. NAME OF CEMETERY OR CREMATORY Field BRANCH		23d. LOCATION (City, town, or county) (State) TAULBEE, KENTUCKY	
24 FUNERAL DIRECTOR'S SIGNATURE The HUNT FUNERAL HOME, WALDORF, MD.				25a. REC'D BY REGISTRAR DATE SEP 20 '61		25b. REGISTRAR'S SIGNATURE C. J. ...	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10622 CERTIFICATE OF DEATH 10622											
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution, give name and address) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>				c. LENGTH OF STAY IN 1b <u>13 DAYS</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SOUTHERN MARYLAND HOSP. CENTER</u>				d. STREET ADDRESS <u>143 PX 579</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MINNIE C WAYMAN</u>		First Middle Last		4. DATE OF DEATH <u>SEPT. 30 1961</u>		Month Day Year					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 31-1876</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>				11. BIRTHPLACE (County & State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PHILLIP BOWEN</u>				14. MOTHER'S MAIDEN NAME <u>EMMA ROADE</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO <u>NONE</u>				17. INFORMANT <u>MRS. GEORGE THORNTON NICK</u> Address <u>127 3rd St 519 CLINTON MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>204.1</u> DUE TO <u>INTRACRANIAL HEMORRHAGE (B.I. TRACT)</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MENINGEAL LEUKEMIA - ALVEOLAR PHASE 13 DAYS</u>											
(c) <u>CONGESTIVE HEART FAILURE (COMPENSATED)</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTE MEDICAL EXAMINER) <u>NONE</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>							
20c. TIME OF INJURY Month, Day, Year <u>NONE</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>NONE</u>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NONE</u>			
20f. (City or town) <u>NONE</u>				20g. (County) <u>NONE</u>				20h. (State) <u>NONE</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>9/17</u> 19 <u>61</u> to <u>PRESENT</u> , that (I) (we) last saw the deceased alive on <u>SEPT 29 1961</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Arthur Shaver Jr MD</u>				22b. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR MD</u>				22c. ADDRESS <u>BRANCH AVE - CLINTON MD</u>			
23a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>10/3/1961</u>				23c. NAME OF CEMETERY OR CREMATORY <u>MARSHALL CEMETERY</u>			
23d. LOCATION (City, town or county) <u>MARSHALL VA</u>				23e. (State) <u>VA</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS</u>				24a. ADDRESS <u>Co-517-115 5150</u>				25a. REC'D BY REGISTRAR <u>OCT 3 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>				25c. DATE <u>OCT 3 '61</u>							



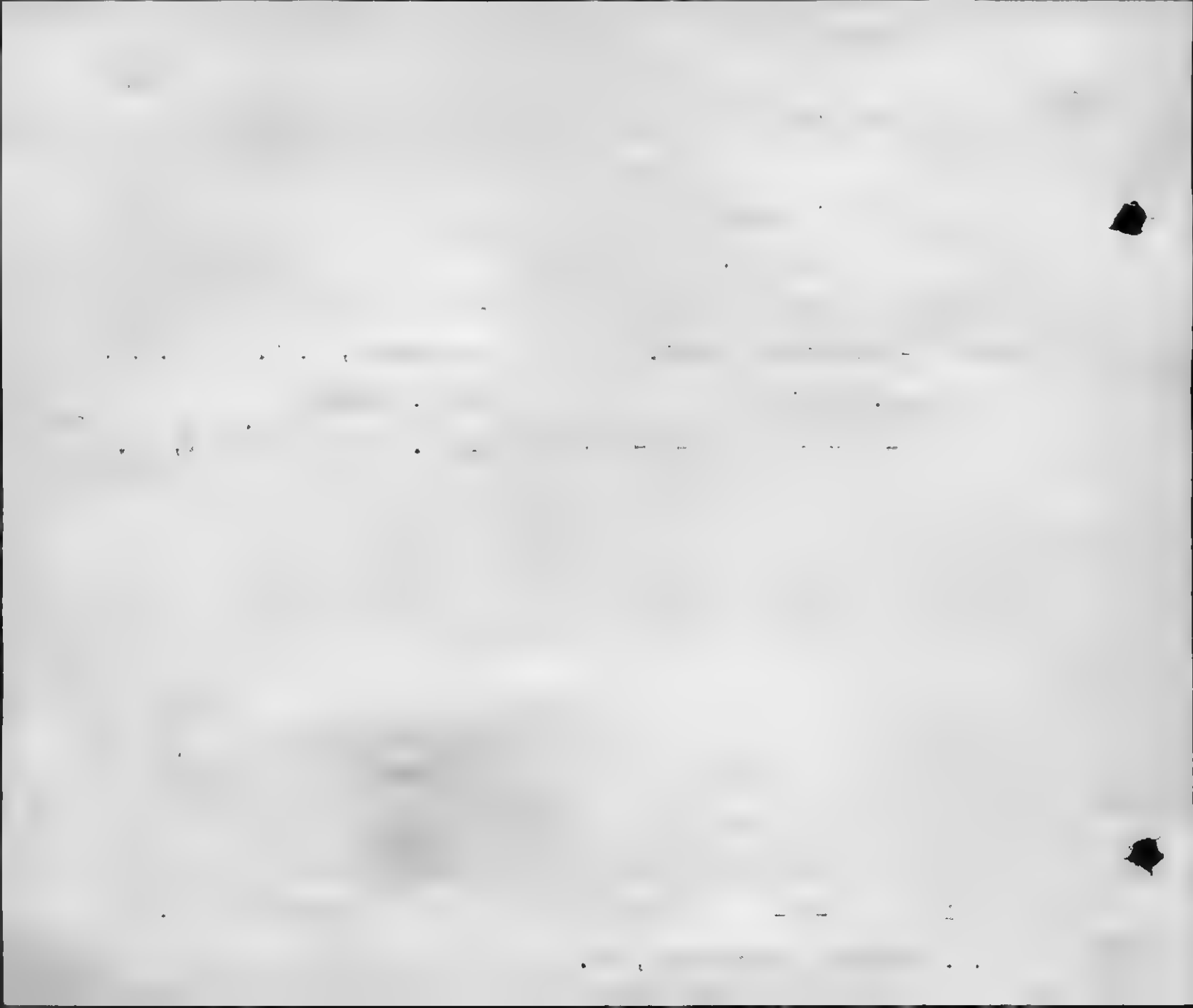
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b> d. STREET ADDRESS <b>32-A Crescent Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nohre M. Wehn</b>		4. DATE OF DEATH <b>September 19 1961</b>		5. SEX <b>Female</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-21-81</b>	
9. AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min. <b>79 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier - (Retired)</b>		11. BIRTHPLACE (Country & State or foreign country) <b>Washington, D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>David C. Holliday</b>		14. MOTHER'S MAIDEN NAME <b>Emma H. Benton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-03-1273</b>		17. INFORMANT <b>Richard G. Wehn</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> <b>351X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>9/17</b> 19 <b>61</b> to <b>9/19</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9/17</b> 19 <b>61</b> , and that death occurred at <b>12:00 PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Louis Mendel</b> 22c. PHYSICIAN'S NAME (Type) <b>LOUIS MENDEL, M.D.</b>		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 22d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>4506 COLLEGE AVE</b> <b>COLLEGE PARK</b> <b>Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-22-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood CEM</b>	
23d. LOCATION (City, town or county) <b>Washington, D.C.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>		24b. ADDRESS <b>Riverdale, Md.</b>	
25a. REC'D BY REGISTRAR <b>SEP 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>		25c. DATE <b>SEP 22 '61</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
3M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>10631 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Leland Memorial Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, indicate before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b> d. STREET ADDRESS <b>12106 Wheatley Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>Alice Alphansane Wheatley</b>				<b>4. DATE OF DEATH</b> <b>September 22 19 61</b>				<b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>JUNE 1, 1918</b> <b>9. AGE</b> (In years last birthday) <b>43</b> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>New York</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S. A</b>			
<b>13. FATHER'S NAME</b> <b>Henry Burnette</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>ELIZABETH TOOMEL</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>224-48-6301</b> <b>17. INFORMANT</b> <b>Edward Earl Wheatley, same as # 2</b>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):</b> <b>FAT INFILTRATION, LIVER</b>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from.</b> <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>22b. DATE THEREOF</b> <b>9-25-61</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Fort Lincoln</b> <b>22d. LOCATION (City, town, or country)</b> <b>Bladensburg, Md.</b>				<b>23. FUNERAL DIRECTOR</b> <b>W. W. Chambers Co. Riverdale, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>SEP 26 '61</b> <b>24b. REGISTRAR'S SIGNATURE</b> <i>Charles S. Thomas</i>			

MEDICAL CERTIFICATION

**DEPUTY MEDICAL EXAMINER'S SIGNATURE**

**EXAMINER'S NAME (Type)**

**James I. Boyd**

M.D.

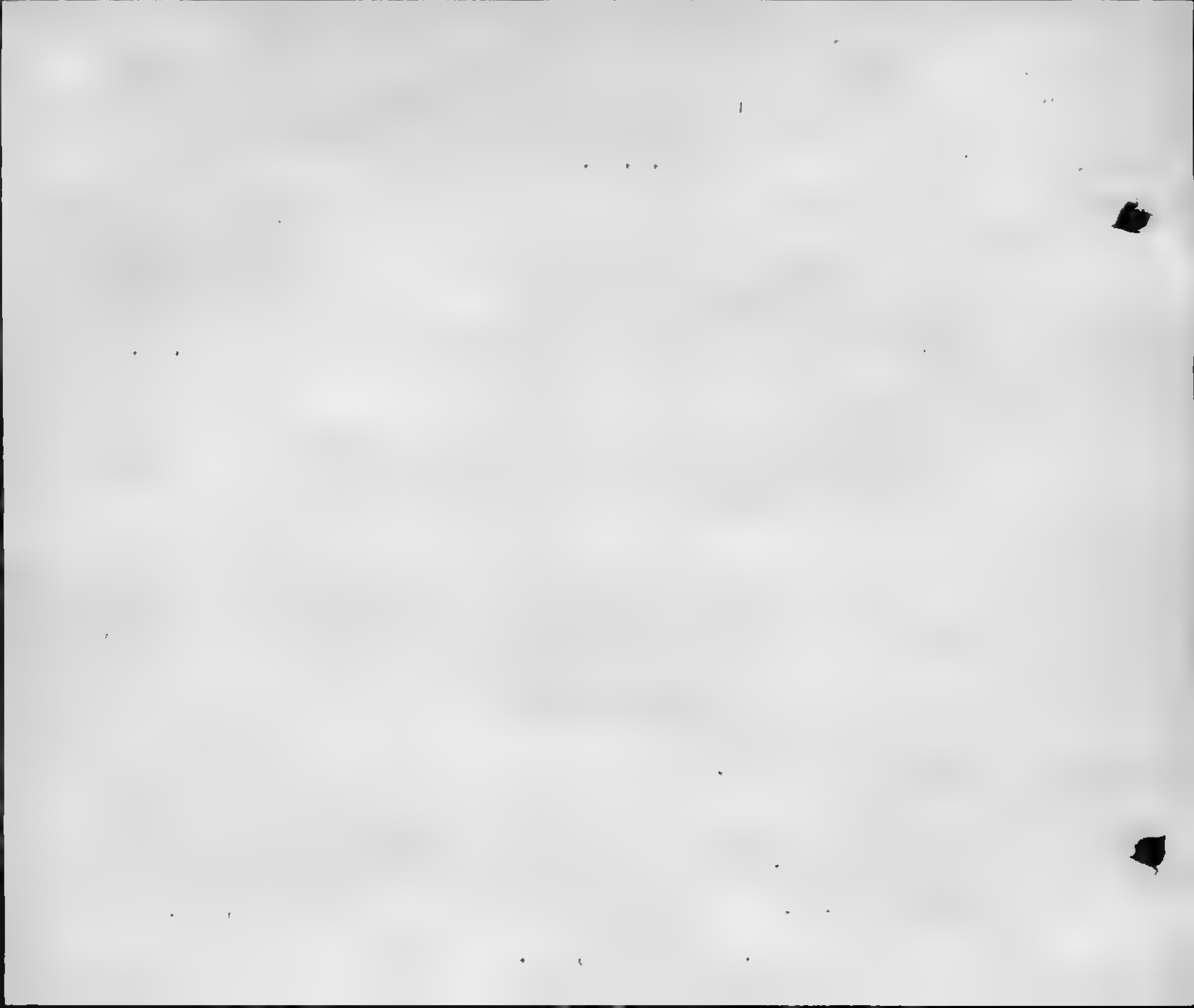
**CHIEF MEDICAL EXAMINER** ☐

**ASSISTANT MEDICAL EXAMINER** ☐

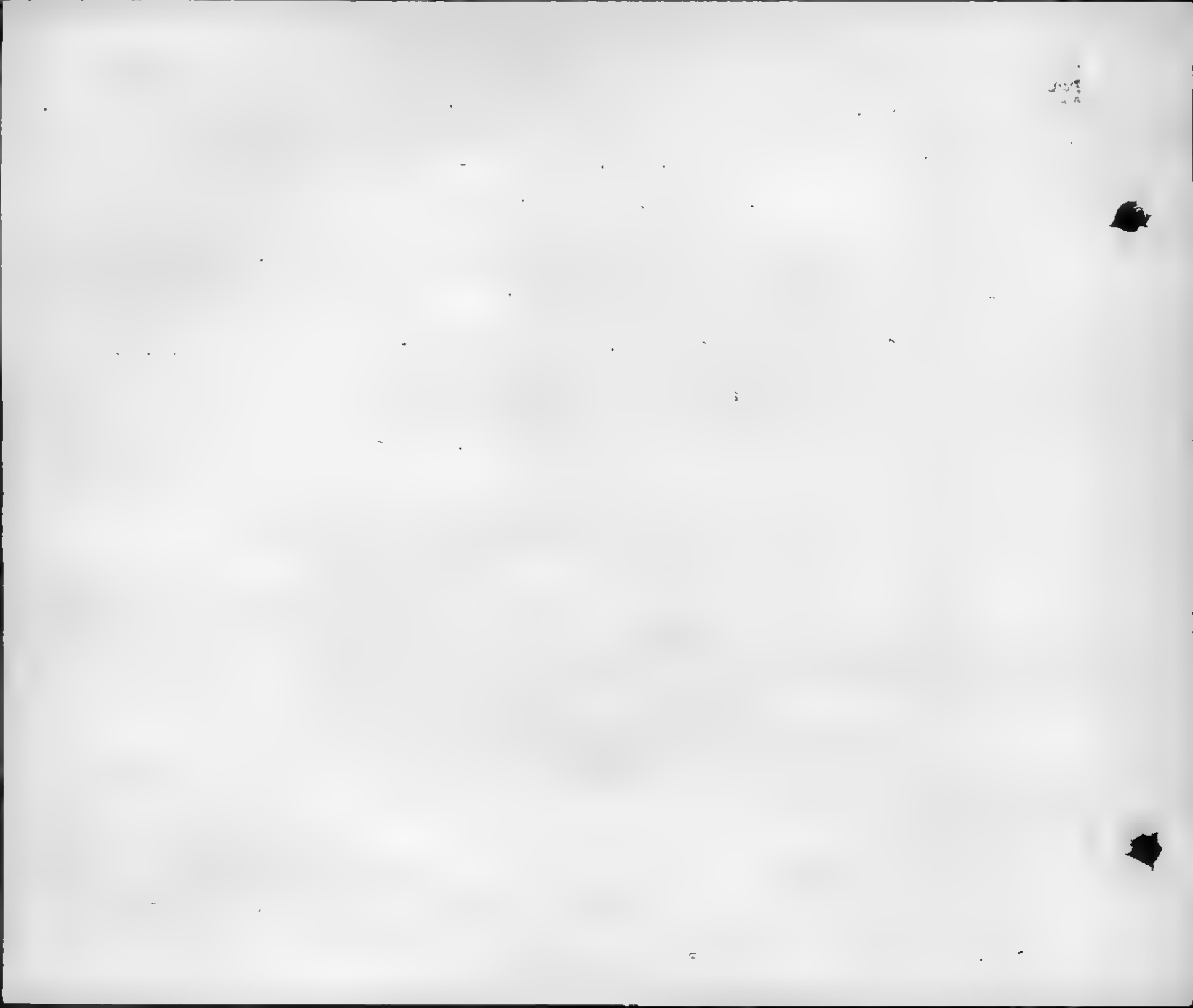
**DEPUTY MEDICAL EXAMINER** ☒

**Address (Street, city, town, or county)**

**DATE SIGNED** **9/22/61**





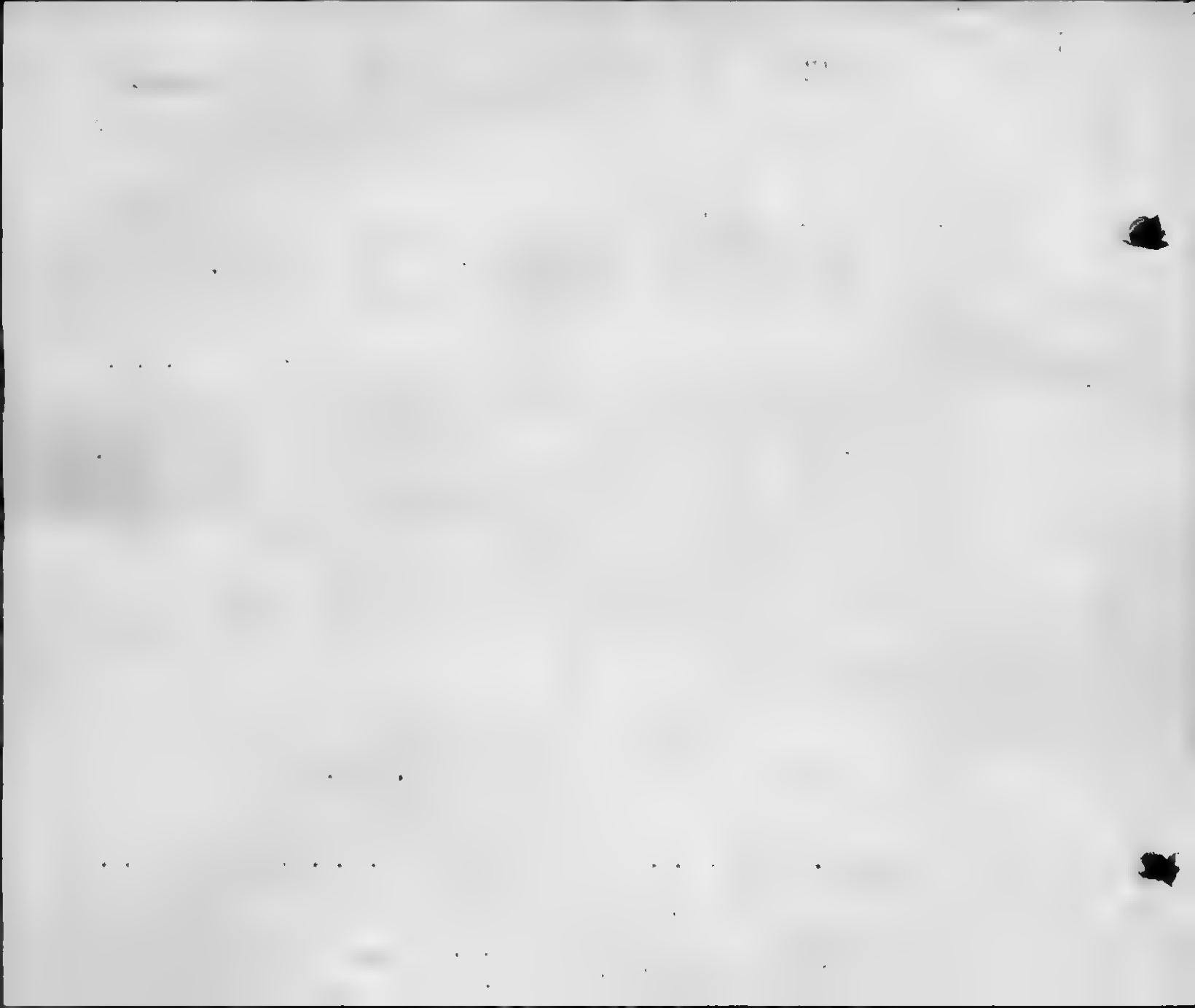


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
10633 Item 13 Film G297 10/2/61 mb 10626			
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie	
c. LENGTH OF STAY IN 1b 10 days		d. STREET ADDRESS 6th Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF (Type or print) Lewis		4. DATE OF DEATH Sept. 27 19 61	
5. SEX Male		6. COLOR OR RACE Black	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 Jan 1917	
9. AGE (in years) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Short order Cook	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Short order Cook		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country & State or foreign country) So. HAMPTON, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nathaniel Woodard		14. MOTHER'S MAIDEN NAME EMMA SCOTT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 517-12-6518	
17. INFORMANT MRS. FRANCES WOODWARD		Address 1418 TH T	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Duodenal ulcer with hemorrhage 41.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH 2 months	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year 9/27 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/17 19 61, to 9/27 19 61, that (I) (we) last saw the deceased alive on 9/27 19 61, and that death occurred at 6:05 PM, from the causes and on the date stated above.		22a. SIGNATURE James R. Goodson, M.D.	
22b. DATE SIGNED 9/27/61		22c. PHYSICIAN'S NAME (Type) James R. Goodson, M.D.	
22d. ADDRESS 1746 K St. N.W. Washington 6 D.C.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10.1.61	
23c. NAME OF CEMETERY OR CREMATORY GLEFIELD CEMETERY		23d. LOCATION (City, town or county) IVOR, VIRGINIA	
23e. ADDRESS 1820 9TH ST., N.W. WASHINGTON, D.C.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 29 '61	



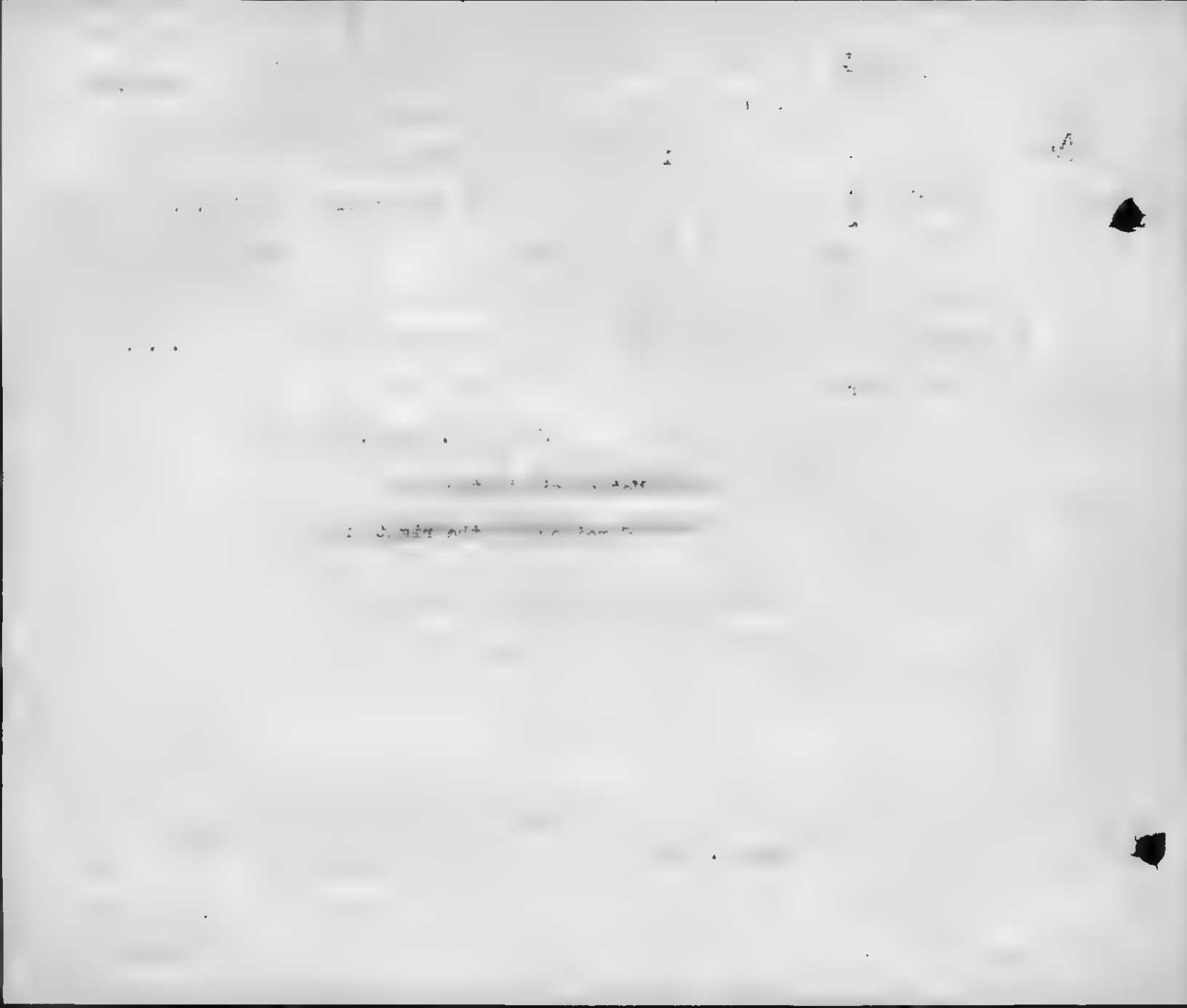
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10634 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Camp Springs c. LENGTH OF STAY IN 1b 1 week d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7263 Brinkley Road						2. USUAL RESIDENCE (Where deceased lived, if institution, specify date of admission) a. STATE District of Columbia b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2829 Gainesville Street S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary Elizabeth Young First Middle Last 4. DATE OF DEATH September 21 19 61 Month Day Year						5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH May 15, 1909 9. AGE (In years, birth day, months, days, hours, min.) 32 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY Own home 11. BIRTHPLACE (State or foreign country) District of Columbia 12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Harry Styron 14. MOTHER'S MAIDEN NAME Mary Hart				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Address William P. Young, same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastasis to the liver DUE TO (b) Carcinoma of the right breast. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9/22/61 Address (Street, city, town, or county) ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) James I. Boyd 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Sept. 25-61 22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. 22d. LOCATION (City, town, or country) Arlington Va. 23. FUNERAL DIRECTOR Address 1661- C St Hope Rd SE WASH DC 24a. REC'D BY REGISTRAR DATE SEP 25 '61 24b. REGISTRAR'S SIGNATURE Arthur L. Hanes											



**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10635

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10628

1. PLACE OF DEATH a. COUNTY		Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution—Residence before admission) a. STATE		Maryland		b. COUNTY		Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cheverly		c. LENGTH OF STAY IN 1b		D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		49 Mt. Rainier	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Prince George's General Hospital		d. STREET ADDRESS		4513 29th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
William		Albert		Young		September 6, 1961					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		May 27, 1888		73 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Maintenance		Govt Printing		Kentucky		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Robert Bruce Young		Caroline Elizabeth Mitchell									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Yes		WW I		Yes.		Rosalind Young, same as # 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH							
420.1 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Coronary artery disease									
		DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
19											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		James I. Boyd		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		September 6, 1961	
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)					
Burial		Sept. 8, 1961		Arlington National		Ft. Myer, Va					
23. FUNERAL DIRECTOR		W. W. Chambers Co.		ADDRESS		24e. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
		5801 Cleveland Ave. Riverdale, Md.				DATE SEP 7 1961					

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TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10636

## CERTIFICATE OF DEATH

Item 23b, Film G295 9/25/61 iwk

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, include hospital admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b> d. STREET ADDRESS <b>4514 Sellman Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert H. Ziepol</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>18,</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 13, 1889</b>
9. AGE (in years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>19</b> Hours <b>61</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Ziepol</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Mann</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>577-10-1191</b>	
17. INFORMANT <b>Elsie G. Ziepol</b>		Address <b>Same as # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic Heart Disease</b> DUE TO <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>24 hrs</b> <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/14</b> to <b>9/18</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9/18</b> , 19 <b>61</b> , and that death occurred at <b>5:30</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Norman Donat Comen</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>NORMAN DONAT COMEN</b>		22d. ADDRESS <b>3503 Penny St MT Rainier Md</b>	
22b. DATE SIGNED <b>9/18/61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 21, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORIA <b>St. John's Church</b>		23d. LOCATION (City, town or county) (State) <b>Beltsville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>	
25a. REC'D BY REGISTRAR <b>SEP 20 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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